February 16, 2007

SENATE BILL No. 503

DIGEST OF SB 503 (Updated February 15, 2007 11:58 am - DI 73)

Citations Affected: IC 4-22; IC 12-7; IC 12-15; IC 12-16; IC 27-8; noncode.

Synopsis: Healthier Indiana insurance program. Establishes the healthier Indiana insurance program and the healthier Indiana insurance program fund. Provides that the office of Medicaid policy and planning may not enroll applicants, approve any contracts to provide services or administer the program, incur costs other than those necessary to study and plan for the program, or create financial obligations for the state unless: (1) there is a specific appropriation from the general assembly to implement the program; and (2) after review by the budget committee, the budget agency approves an actuarial analysis that determines sufficient funding is reasonably estimated to be available to operate the program for at least the following eight years. Makes funding changes to the hospital care for the indigent program, the municipal disproportionate share program, and the Medicaid indigent care trust fund. Requires the Indiana comprehensive health insurance association to provide, and referred program participants to participate in, medical management services. Requires the office of Medicaid policy and planning to apply to the United States Department of Health and Human Services for a demonstration waiver to develop and implement the healthier Indiana insurance program to cover certain individuals.

Effective: Upon passage; July 1, 2007.

Miller, Simpson, Becker, Errington, Sipes, Rogers, Riegsecker

January 23, 2007, read first time and referred to Committee on Health and Provider Services.
February 8, 2007, amended, reported favorably — Do Pass; reassigned to Committee on Appropriations.
February 15, 2007, amended, reported favorably — Do Pass.

February 16, 2007

First Regular Session 115th General Assembly (2007)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2006 Regular Session of the General Assembly.

SENATE BILL No. 503

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 4-22-2-37.1, AS AMENDED BY P.L.47-2006, SECTION 2, AS AMENDED BY P.L.91-2006, SECTION 2, AND AS AMENDED BY P.L.123-2006, SECTION 12, IS CORRECTED AND AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 37.1. (a) This section applies to a rulemaking action resulting in any of the following rules:

(1) An order adopted by the commissioner of the Indiana department of transportation under IC 9-20-1-3(d) or IC 9-21-4-7(a) and designated by the commissioner as an emergency rule.

(2) An action taken by the director of the department of natural resources under IC 14-22-2-6(d) or IC 14-22-6-13.

(3) An emergency temporary standard adopted by the occupational safety standards commission under IC 22-8-1.1-16.1.

(4) An emergency rule adopted by the solid waste management board under IC 13-22-2-3 and classifying a waste as hazardous.

(5) A rule, other than a rule described in subdivision (6), adopted by the department of financial institutions under IC 24-4.5-6-107 and declared necessary to meet an emergency.

(6) A rule required under IC 24-4.5-1-106 that is adopted by the department of financial institutions and declared necessary to meet an emergency under IC 24-4.5-6-107.

(7) A rule adopted by the Indiana utility regulatory commission to address an emergency under IC 8-1-2-113.

(8) An emergency rule adopted by the state lottery commission under IC 4-30-3-9.

(9) A rule adopted under IC 16-19-3-5 that the executive board of the state department of health declares is necessary to meet an emergency.

(10) An emergency rule adopted by the Indiana finance authority under IC 8-21-12.

(11) An emergency rule adopted by the insurance commissioner under IC 27-1-23-7.

(12) An emergency rule adopted by the Indiana horse racing commission under IC 4-31-3-9.

(13) An emergency rule adopted by the air pollution control board, the solid waste management board, or the water pollution control board under IC 13-15-4-10(4) or to comply with a deadline required by federal law, provided:

(A) the variance procedures are included in the rules; and

(B) permits or licenses granted during the period the emergency rule is in effect are reviewed after the emergency rule expires.

(14) An emergency rule adopted by the Indiana election commission under IC 3-6-4.1-14.

(15) An emergency rule adopted by the department of natural resources under IC 14-10-2-5.

(16) An emergency rule adopted by the Indiana gaming commission under *IC 4-32.2-3-3(b),* IC 4-33-4-2, IC 4-33-4-3, or IC 4-33-4-14.

(17) An emergency rule adopted by the alcohol and tobacco commission under IC 7.1-3-17.5, IC 7.1-3-17.7, or IC 7.1-3-20-24.4.

(18) An emergency rule adopted by the department of financial institutions under IC 28-15-11.

(19) An emergency rule adopted by the office of the secretary of family and social services under IC 12-8-1-12.

(20) An emergency rule adopted by the office of the children's

health insurance program under IC 12-17.6-2-11.

(21) An emergency rule adopted by the office of Medicaid policy and planning under IC 12-15-41-15 **or IC 12-15-44-16.**

(22) An emergency rule adopted by the Indiana state board of animal health under IC 15-2.1-18-21.

(23) An emergency rule adopted by the board of directors of the Indiana education savings authority under IC 21-9-4-7.

(24) An emergency rule adopted by the Indiana board of tax review under IC 6-1.1-4-34 **(repealed).**

(25) An emergency rule adopted by the department of local government finance under IC 6-1.1-4-33 **(repealed).**

(26) An emergency rule adopted by the boiler and pressure vessel rules board under IC 22-13-2-8(c).

(27) An emergency rule adopted by the Indiana board of tax review under IC 6-1.1-4-37(l) **(repealed)** or an emergency rule adopted by the department of local government finance under IC 6-1.1-4-36(j) **(repealed)** or IC 6-1.1-22.5-20.

(28) An emergency rule adopted by the board of the Indiana economic development corporation under IC 5-28-5-8.

(29) A rule adopted by the department of financial institutions under IC 34-55-10-2.5.

(30) A rule adopted by the Indiana finance authority:

(A) under IC 8-15.5-7 approving user fees (as defined in IC 8-15.5-2-10) provided for in a public-private agreement under IC 8-15.5;

(B) under IC 8-15-2-17.2(a)(10):

(i) establishing enforcement procedures; and

(ii) making assessments for failure to pay required tolls;

(C) under IC 8-15-2-14(a)(3) authorizing the use of and establishing procedures for the implementation of the collection of user fees by electronic or other nonmanual means; or

(D) to make other changes to existing rules related to a toll road project to accommodate the provisions of a public-private agreement under IC 8-15.5.

(b) The following do not apply to rules described in subsection (a):

(1) Sections 24 through 36 of this chapter.

(2) IC 13-14-9.

(c) After a rule described in subsection (a) has been adopted by the agency, the agency shall submit the rule to the publisher for the assignment of a document control number. The agency shall submit the rule in the form required by section 20 of this chapter and with the

documents required by section 21 of this chapter. The publisher shall determine the ~~*number of copies*~~ *format* of the rule and other documents to be submitted under this subsection.

(d) After the document control number has been assigned, the agency shall submit the rule to the ~~*secretary of state*~~ *publisher* for filing. The agency shall submit the rule in the form required by section 20 of this chapter and with the documents required by section 21 of this chapter. The ~~*secretary of state*~~ *publisher* shall determine the ~~*number of copies*~~ *format* of the rule and other documents to be submitted under this subsection.

(e) Subject to section 39 of this chapter, the ~~*secretary of state*~~ *publisher* shall:

(1) accept the rule for filing; and

(2) ~~*file stamp and indicate*~~ *electronically record* the date and time that the rule is accepted. ~~*on every duplicate original copy submitted.*~~

(f) A rule described in subsection (a) takes effect on the latest of the following dates:

(1) The effective date of the statute delegating authority to the agency to adopt the rule.

(2) The date and time that the rule is accepted for filing under subsection (e).

(3) The effective date stated by the adopting agency in the rule.

(4) The date of compliance with every requirement established by law as a prerequisite to the adoption or effectiveness of the rule.

(g) Subject to subsection (h), IC 14-10-2-5, IC 14-22-2-6, IC 22-8-1.1-16.1, and IC 22-13-2-8(c), and except as provided in subsections (j), ~~*and*~~ (k), *and (l),* a rule adopted under this section expires not later than ninety (90) days after the rule is accepted for filing under subsection (e). Except for a rule adopted under subsection (a)(13), (a)(24), (a)(25), or (a)(27), the rule may be extended by adopting another rule under this section, but only for one (1) extension period. The extension period for a rule adopted under subsection (a)(28) may not exceed the period for which the original rule was in effect. A rule adopted under subsection (a)(13) may be extended for two (2) extension periods. Subject to subsection (j), a rule adopted under subsection (a)(24), (a)(25), or (a)(27) may be extended for an unlimited number of extension periods. Except for a rule adopted under subsection (a)(13), for a rule adopted under this section to be effective after one (1) extension period, the rule must be adopted under:

(1) sections 24 through 36 of this chapter; or

(2) IC 13-14-9;

as applicable.

(h) A rule described in subsection (a)(6), (a)(8), (a)(12), or (a)(29) expires on the earlier of the following dates:

(1) The expiration date stated by the adopting agency in the rule.

(2) The date that the rule is amended or repealed by a later rule adopted under sections 24 through 36 of this chapter or this section.

(i) This section may not be used to readopt a rule under IC 4-22-2.5.

(j) A rule described in subsection (a)(24) or (a)(25) expires not later than January 1, 2006.

(k) A rule described in subsection (a)(28) expires on the expiration date stated by the board of the Indiana economic development corporation in the rule.

(l) A rule described in subsection (a)(30) expires on the expiration date stated by the Indiana finance authority in the rule.

SECTION 2. IC 12-7-2-52.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 52.5. "Custodial parent", for purposes of IC 12-15-44, has the meaning set forth in IC 12-15-44-1.**

SECTION 3. IC 12-7-2-144.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 144.3. "Preventative care services", for purposes of IC 12-15-44, has the meaning set forth in IC 12-15-44-2.**

SECTION 4. IC 12-7-2-146 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 146. "Program" refers to the following:

(1) For purposes of IC 12-10-7, the adult guardianship services program established by IC 12-10-7-5.

(2) For purposes of IC 12-10-10, the meaning set forth in IC 12-10-10-5.

(3) For purposes of IC 12-17.6, the meaning set forth in IC 12-17.6-1-5.

(4) For purposes of IC 12-15-44, the meaning set forth in IC 12-15-44-3.

SECTION 5. IC 12-15-15-1.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.1. (a) This section applies to a hospital that is:

(1) licensed under IC 16-21; and

(2) established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

(b) For a state fiscal year ending after June 30, 2003, in addition to

reimbursement received under section 1 of this chapter, a hospital is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the aggregate inpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

STEP TWO: For the aggregate inpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office for the inpatient hospital services described in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Subject to subsection (g), from the amount calculated under STEP FOUR, allocate to a hospital established and operated under IC 16-22-8 an amount equal to one hundred percent (100%) of the difference between:

(A) the total cost for the hospital's provision of inpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year; and

(B) the total payment to the hospital for its provision of inpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.

STEP SEVEN: Distribute an amount equal to the amount calculated under STEP SIX to the eligible hospitals established and operated under IC 16-22-2 or IC 16-23 described in subsection (c) in proportion to each hospital's Medicaid ~~shortfall~~ **supplemental payment** as defined in subsection (f).

(c) Subject to subsection (e), reimbursement for a state fiscal year under this section consists of payments made after the close of each state fiscal year. ~~Payment for a state fiscal year ending after June 30, 2003, shall be made before December 31 following the state fiscal year's end.~~ A hospital is not eligible for a payment described in this

subsection unless an intergovernmental transfer is made under subsection (d).

(d) Subject to subsection (e), a hospital may make an intergovernmental transfer under this subsection, or an intergovernmental transfer may be made on behalf of the hospital, after the close of each state fiscal year. An intergovernmental transfer under this subsection must be made to the Medicaid indigent care trust fund in an amount equal to a percentage, as determined by the office, of the amount to be distributed to the hospital under ~~STEP SEVEN of subsection (b). In determining the percentage, the office shall apply the same percentage of not more than eighty-five percent (85%) to all hospitals eligible for reimbursement under STEP SEVEN of subsection (b).~~ **this section.** The office shall use the intergovernmental transfer to fund payments made under this section. ~~and as otherwise provided under IC 12-15-20-2(8).~~

(e) A hospital making an intergovernmental transfer under ~~subsection (d)~~ **this section** may appeal under IC 4-21.5 the amount determined by the office to be paid the hospital under ~~STEP SEVEN of~~ subsection (b). The periods described in subsections (c) and (d) for the hospital to make an intergovernmental transfer are tolled pending the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5. The distribution to other hospitals under ~~STEP SEVEN of~~ subsection (b) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under ~~STEP SEVEN of~~ subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals shall be made. A partial distribution may be based upon estimates and trends calculated by the office.

(f) For purposes of this section:

(1) the Medicaid ~~shortfall~~ **supplemental payment** of a hospital established and operated under IC 16-22-2 or IC 16-23 is calculated as follows:

STEP ONE: The office shall identify the inpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospital.

STEP TWO: For the inpatient hospital services identified under STEP ONE, the office shall calculate the payments made under this article and under the state Medicaid plan to the hospital, excluding payments under IC 12-15-16,

IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid by the office for the inpatient hospital services described in STEP ONE under Medicare payment principles; and

(2) a hospital's Medicaid ~~shortfall~~ **supplemental payment** is equal to the amount by which the amount calculated in STEP THREE of subdivision (1) is greater than the amount calculated in STEP TWO of subdivision (1).

(g) The actual distribution of the amount calculated under STEP FIVE of subsection (b) to a hospital established and operated under IC 16-22-8 shall be made under the terms and conditions provided for the hospital in the state plan for medical assistance. Payment to a hospital under STEP FIVE of subsection (b) is not a condition precedent to the tender of payments to hospitals under STEP SEVEN of subsection (b).

SECTION 6. IC 12-15-15-1.3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.3. (a) This section applies to a hospital that is:

(1) licensed under IC 16-21; and

(2) established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

(b) For a state fiscal year ending after June 30, 2003, in addition to reimbursement received under section 1 of this chapter, a hospital is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the aggregate outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

STEP TWO: For the aggregate outpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office under Medicare payment principles for the outpatient hospital services described in STEP ONE.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Subject to subsection (g), from the amount calculated under STEP FOUR, allocate to a hospital established and operated under IC 16-22-8 an amount equal to one hundred percent (100%) of the difference between:

(A) the total cost for the hospital's provision of outpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year; and

(B) the total payment to the hospital for its provision of outpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.

STEP SEVEN: Distribute an amount equal to the amount calculated under STEP SIX to the eligible hospitals established and operated under IC 16-22-2 or IC 16-23 described in subsection (c) in proportion to each hospital's Medicaid ~~shortfall~~ **supplemental payment** as defined in subsection (f).

(c) ~~Subject to subsection (e), the reimbursement for a state fiscal year under this section consists of payments made before December 31 following the end of the state fiscal year.~~ A hospital is not eligible for a payment described in this ~~subsection~~ **section** unless an intergovernmental transfer is made ~~under subsection (d).~~ **by the hospital or on behalf of the hospital.**

(d) Subject to subsection (e), a hospital may make an intergovernmental transfer under this subsection, or an intergovernmental transfer may be made on behalf of the hospital, after the close of each state fiscal year. An intergovernmental transfer under this subsection must be made to the Medicaid indigent care trust fund in an amount equal to a percentage, as determined by the office, of the amount to be distributed to the hospital under ~~STEP SEVEN of~~ subsection (b). ~~In determining the percentage, the office shall apply the same percentage of not more than eighty-five percent (85%) to all hospitals eligible for reimbursement under STEP SEVEN of subsection (b).~~ The office shall use the intergovernmental transfer to fund payments made under this section. ~~and as otherwise provided under IC 12-15-20-2(8).~~

(e) A hospital making an intergovernmental transfer under ~~subsection (d)~~ **this section** may appeal under IC 4-21.5 the amount determined by the office to be paid by the hospital under ~~STEP SEVEN of~~ subsection (b). The periods described in subsections (c) and (d) for the hospital to make an intergovernmental transfer are tolled pending

the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5. The distribution to other hospitals under ~~STEP SEVEN of~~ subsection (b) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under ~~STEP SEVEN of~~ subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals must be made. A partial distribution may be calculated by the office based upon estimates and trends.

(f) For purposes of this section:

(1) the Medicaid ~~shortfall~~ **supplemental payment** of a hospital established and operated under IC 16-22-2 or IC 16-23 is calculated as follows:

STEP ONE: The office shall identify the outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospital.

STEP TWO: For the outpatient hospital services identified under STEP ONE, the office shall calculate the payments made under this article and under the state Medicaid plan to the hospital, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid by the office for the outpatient hospital services described in STEP ONE under Medicare payment principles; and

(2) a hospital's Medicaid ~~shortfall~~ **supplemental payment** is equal to the amount by which the amount calculated in STEP THREE of subdivision (1) is greater than the amount calculated in STEP TWO of subdivision (1).

(g) The actual distribution of the amount calculated under STEP FIVE of subsection (b) to a hospital established and operated under IC 16-22-8 shall be made under the terms and conditions provided for the hospital in the state plan for medical assistance. Payment to a hospital under STEP FIVE of subsection (b) is not a condition precedent to the tender of payments to hospitals under STEP SEVEN of subsection (b).

SECTION 7. IC 12-15-15-1.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.5. (a) This section applies to a hospital that:

(1) is licensed under IC 16-21;

(2) is not a unit of state or local government; and

(3) is not owned or operated by a unit of state or local government.

(b) For a state fiscal year ending after June 30, 2003, **and before July 1, 2005,** in addition to reimbursement received under section 1 of this chapter, a hospital eligible under this section is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the total inpatient hospital services and the total outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospitals described in subsection (a).

STEP TWO: For the total inpatient hospital services and the total outpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals described in subsection (a), excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office for the inpatient hospital services and the outpatient hospital services identified in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) Subject to the availability of funds under IC 12-15-20-2(8)(D) to serve as the non-federal share of such payment, the first ten million dollars ($10,000,000) of the amount calculated under STEP FOUR for a state fiscal year shall be paid to a hospital described in subsection (a) that has more than seventy thousand (70,000) Medicaid inpatient days.

(B) Following the payment to the hospital under clause (A) and subject to the availability of funds under IC 12-15-20-2(8)(D) to serve as the non-federal share of such payments, the remaining amount calculated under STEP FOUR for a state fiscal year shall be paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis based on the hospitals' Medicaid inpatient days or other payment methodology approved by the Centers for

Medicare and Medicaid Services.

(C) Subject to IC 12-15-20.7, in the event the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) and (B), the remaining amount may be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause only if the non-federal share of the hospital's payment is provided by or on behalf of the hospital. The remaining amount shall be paid to those eligible hospitals on a pro rata basis in relation to all hospitals eligible under this clause based on the hospitals' Medicaid inpatient days or other payment methodology approved by the Centers for Medicare and Medicaid Services.

(D) For purposes of the clauses (A), (B) and (C), a hospital's Medicaid inpatient days are based on the Medicaid inpatient days allowed for the hospital by the office for purposes of the office's most recent determination of eligibility for the Medicaid disproportionate payment program under IC 12-15-16.

~~(c) Reimbursement for a state fiscal year under this section consists of payments made after the close of each state fiscal year. Payment for a state fiscal year ending after June 30, 2003, shall be made before December 31 following the end of the state fiscal year.~~

(c) For state fiscal years ending after July 1, 2005, in addition to reimbursement received under section 1 of this chapter, a hospital eligible under this section is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the total inpatient hospital services and the total outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by a hospital described in subsection (a).

STEP TWO: For the total inpatient hospital services and the total outpatient hospital services identified under STEP ONE, the office shall calculate the total payments made under this article and under the state Medicaid plan to a hospital described in subsection (a), excluding payments made under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the total amount that would have been paid by the office for the inpatient hospital services and the outpatient hospital services identified in STEP ONE under Medicare

payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) Subject to the availability of funds under IC 12-15-20-2(8) to serve as the non-federal share of the payments, the amount calculated under STEP FOUR for a state fiscal year shall be paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis based on the hospitals' Medicaid inpatient days or, if the federal Centers for Medicare and Medicaid Services does not approve that methodology, another payment methodology approved by the federal Centers for Medicare and Medicaid Services. For purposes of this clause, a hospital's Medicaid inpatient days are the hospital's in-state Medicaid fee for service and managed care paid days for the state fiscal year referenced in STEP ONE, as determined by the office.

(B) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clause (A), the remaining amount shall be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause only if the hospital:

(i) has less than seventy thousand (70,000) Medicaid inpatient days annually;

(ii) was eligible for Medicaid disproportionate share hospital payments for the state fiscal year ending June 30, 1998, or the hospital met the office's Medicaid disproportionate share payment criteria for payment under IC 12-15-19-2.1 based upon state fiscal year 1998 data and received a Medicaid disproportionate share payment for the state fiscal year ending June 30, 2001; and

(iii) received a Medicaid disproportionate share payment under IC 12-15-19-2.1 for state fiscal years 2001, 2002, 2003, and 2004.

The amount of a hospital's payment under this clause is subject to the availability of Medicaid indigent care trust funds or, if none are available, the non-federal share of the

hospital's payment being provided by or on behalf of the hospital. The payment to each hospital shall equal the hospital's hospital specific limit, as defined under 42 U.S.C. 1396r-4, when the payment is combined with any other Medicaid payments made to the hospital. For state fiscal years ending before July 1, 2008, the total payments made under this clause may not exceed a total amount of sixty-eight million dollars ($68,000,000). For a state fiscal year ending after June 30, 2008, the total payments made under this clause may not exceed a total amount of sixty-eight million dollars ($68,000,000) plus the annual percentage growth in the state's aggregate Medicaid upper payment limit, as calculated by the office.

(C) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) and (B), the remaining amount may be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause if the hospital:

(i) has less than seventy thousand (70,000) Medicaid inpatient days annually;

(ii) has received or is eligible to receive Medicaid disproportionate share payments under IC 12-15-19-2.1 for state fiscal years 2002, 2003, 2004, and for each state fiscal year after 2004; and

(iii) provides, or has provided on the hospital's behalf, the non-federal share of the hospital's payment.

A payment to a hospital under this clause is subject to the availability of non-federal matching funds. The payment to each hospital shall not exceed ninety percent (90%) of the hospital's Medicaid shortfall. As used in this clause, Medicaid shortfall is the amount of the hospital's Medicaid costs less the hospital's Medicaid reimbursement, including any payments received by the hospital under IC 12-15-15-9 and IC 12-15-15-9.5. For state fiscal years ending before July 1, 2008, the total payments made under this clause may not exceed a total amount of twenty-three million five hundred thousand dollars ($23,500,000). For a state fiscal year ending after June 30, 2008, the total payments made under this clause may not exceed a total amount of twenty-three million five hundred thousand dollars ($23,500,000) plus the annual percentage growth in the

state's aggregate Medicaid upper payment limit, as determined by the office.

(D) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) through (C), the remaining amount shall be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for payment under this clause if the hospital provides, or has provided on the hospital's behalf, the non-federal share of the hospital's payment.

(E) As used in clauses (A) through (D), a hospital's Medicaid inpatient days are based on the hospital's in-state Medicaid fee for service and managed care paid days for the state fiscal year referenced in STEP ONE, as determined by the office.

(d) A hospital described in subsection (a) may appeal under IC 4-21.5 the amount determined by the office to be paid to the hospital under STEP FIVE of subsection (b) **or subsection (c).** The distribution to other hospitals under STEP FIVE of subsection (b) **or subsection (c)** may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under STEP FIVE of subsection (b) **or subsection (c)** pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals shall be made. A partial distribution may be based on estimates and trends calculated by the office.

SECTION 8. IC 12-15-15-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and:

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, **and before July 1, 2006,** a hospital licensed under IC 16-21-2 that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5 is entitled to a payment under ~~this section.~~ **subsection (c).**

(c) Except as provided in section 9.8 of this chapter and subject to section 9.6 of this chapter, for a state fiscal year, the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP SIX of the following STEPS:

STEP ONE: Identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 during the state fiscal year; and

(B) the county to which each payable claim is attributed.

STEP TWO: For each county identified in STEP ONE, identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 attributed to the county during the state fiscal year; and

(B) the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP THREE: For each county identified in STEP ONE, identify the amount of county funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP FOUR: For each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, calculate the hospital's percentage share of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b). Each hospital's percentage share is based on the total amount of the hospital's payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year, calculated as a percentage of the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP FIVE: Subject to subsection (j), for each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, multiply the hospital's percentage share calculated under STEP FOUR by the amount of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP SIX: Determine the sum of all amounts calculated under

STEP FIVE for each hospital identified in STEP ONE with respect to each county identified in STEP ONE.

(d) For state fiscal years beginning after June 30, 2006, a hospital that received a payment determined under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2006, shall be paid in an amount equal to the amount determined for the hospital under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2006.

~~(d)~~ **(e)** A hospital's payment under subsection (c) **or (d)** is in the form of a Medicaid ~~add-on~~ **supplemental** payment. The amount of a hospital's ~~add-on~~ **Medicaid supplemental** payment is subject to the availability of funding for the non-federal share of the payment under subsection ~~(c).~~ **(f).** The office shall make the payments under ~~subsection~~ **subsections** (c) **and (d)** before December 15 that next succeeds the end of the state fiscal year.

~~(e)~~ **(f)** The non-federal share of a payment to a hospital under subsection (c) **or (d)** is funded from the funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) of each county to which a payable claim under IC 12-16-7.5 submitted to the division during the state fiscal year by the hospital is attributed.

~~(f)~~ **(g)** The amount of a county's transferred funds available to be used to fund the non-federal share of a payment to a hospital under subsection (c) **or (d)** is an amount that bears the same proportion to the total amount of funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) that the total amount of the hospital's payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year bears to the total amount of all hospital payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year.

~~(g)~~ **(h)** Any county's funds identified in subsection ~~(f)~~ **(g)** that remain after the non-federal share of a hospital's payment has been funded are available to serve as the non-federal share of a payment to a hospital under section 9.5 of this chapter.

~~(h)~~ **(i)** For purposes of this section, "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).

~~(i)~~ **(j)** For purposes of this section:

(1) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under

IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(2) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

~~(j)~~ **(k)** The amount calculated under STEP FIVE of subsection (c) for a hospital with respect to a county may not exceed the total amount of the hospital's payable claims attributed to the county during the state fiscal year.

SECTION 9. IC 12-15-15-9.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9.5. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and;

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, **but before July 1, 2006,** a hospital licensed under IC 16-21-2:

(1) that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5; and

(2) whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year;

is entitled to a payment under ~~this section.~~ **subsection (c).**

(c) Except as provided in section 9.8 of this chapter and subject to section 9.6 of this chapter, for a state fiscal year, the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP EIGHT of the following STEPS:

STEP ONE: Identify each county whose transfer of funds to the Medicaid indigent care trust fund under STEP FOUR of

IC 12-16-7.5-4.5(b) for the state fiscal year was less than the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP TWO: For each county identified in STEP ONE, calculate the difference between the amount of funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP THREE: Calculate the sum of the amounts calculated for the counties under STEP TWO.

STEP FOUR: Identify each hospital whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP FIVE: Calculate for each hospital identified in STEP FOUR the difference between the hospital's payment under section 9(c) of this chapter and the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP SIX: Calculate the sum of the amounts calculated for each of the hospitals under STEP FIVE.

STEP SEVEN: For each hospital identified in STEP FOUR, calculate the hospital's percentage share of the amount calculated under STEP SIX. Each hospital's percentage share is based on the amount calculated for the hospital under STEP FIVE calculated as a percentage of the sum calculated under STEP SIX.

STEP EIGHT: For each hospital identified in STEP FOUR, multiply the hospital's percentage share calculated under STEP SEVEN by the sum calculated under STEP THREE. The amount calculated under this STEP for a hospital may not exceed the amount by which the hospital's total payable claims under IC 12-16-7.5 submitted during the state fiscal year exceeded the amount of the hospital's payment under section 9(c) of this chapter.

(d) For state fiscal years beginning after June 30, 2006, a hospital that received a payment determined under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2006, will be paid an amount equal to the amount determined for the hospital under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2006.

~~(d)~~ **(e)** A hospital's payment under subsection (c) **or (d)** is in the

form of a Medicaid ~~add-on~~ **supplemental** payment. The amount of the hospital's add-on payment is subject to the availability of funding for the non-federal share of the payment under subsection ~~(c).~~ **(f).** The office shall make the payments under subsection (c) **or (d)** before December 15 that next succeeds the end of the state fiscal year.

~~(c)~~ **(f)** The non-federal share of a payment to a hospital under subsection (c) **or (d)** is derived from funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and not expended under section 9 of this chapter. ~~To the extent possible, the funds shall be derived on a proportional basis from the funds transferred by each county identified in subsection (c), STEP ONE:~~

~~(1) to which at least one (1) payable claim submitted by the hospital to the division during the state fiscal year is attributed; and~~

~~(2) whose funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) were not completely expended under section 9 of this chapter.~~

~~The amount available to be derived from the remaining funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) to serve as the non-federal share of the payment to a hospital under subsection (c) is an amount that bears the same proportion to the total amount of funds transferred by all the counties identified in subsection (c), STEP ONE, that the amount calculated for the hospital under subsection (c), STEP FIVE, bears to the amount calculated under subsection (c), STEP SIX.~~

~~(f)~~ **(g)** Except as provided in subsection ~~(g),~~ **(h),** the office may not make a payment under this section until the payments due under section 9 of this chapter for the state fiscal year have been made.

~~(g)~~ **(h)** If a hospital appeals a decision by the office regarding the hospital's payment under section 9 of this chapter, the office may make payments under this section before all payments due under section 9 of this chapter are made if:

(1) a delay in one (1) or more payments under section 9 of this chapter resulted from the appeal; and

(2) the office determines that making payments under this section while the appeal is pending will not unreasonably affect the interests of hospitals eligible for a payment under this section.

~~(h)~~ **(i)** Any funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) remaining after payments are made under this section shall be used as provided in ~~IC 12-15-20-2(8)(D).~~ **IC 12-15-20-2(8).**

~~(i)~~ **(j)** For purposes of this section:

(1) "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b);

(2) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(3) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

SECTION 10. IC 12-15-15-9.8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9.8. ~~(a) This section applies only if the office determines, based on information received from the United States Centers for Medicare and Medicaid Services, that a state Medicaid plan amendment implementing the payment methodology in:~~

~~(1) section 9(c) of this chapter; or~~

~~(2) section 9.5(c) of this chapter;~~

~~will not be approved by the United States Centers for Medicare and Medicaid Services.~~

~~(b)~~ The office may amend the state Medicaid plan to implement an alternative payment methodology. ~~to the payment methodology under section 9 of this chapter. The alternative payment methodology must provide each hospital that would have received a payment under section 9(c) of this chapter during a state fiscal year with an amount for the state fiscal year that is as equal as possible to the amount each hospital would have received under the payment methodology under section 9(c) of this chapter. A payment methodology implemented under this subsection is in place of the payment methodology under section 9(c) of this chapter.~~

~~(c) The office may amend the state Medicaid plan to implement an alternative payment methodology to the payment methodology under section 9.5 of this chapter. The alternative payment methodology must provide each hospital that would have received a payment under section 9.5(c) of this chapter during a state fiscal year with an amount for the state fiscal year that is as equal as possible to the amount each hospital would have received under the payment methodology under section 9.5(c) of this chapter. A payment methodology implemented under this subsection is in place of the payment methodology under section 9.5(c) of this chapter.~~

SECTION 11. IC 12-15-15-10 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 10. (a) This section applies to a hospital that:

(1) is licensed under IC 16-21; and

(2) qualifies as a provider under **IC 12-15-16, IC 12-15-17, or IC 12-15-19 of** the Medicaid disproportionate share provider program.

(b) The office may, after consulting with affected providers, do one (1) or more of the following:

~~(1) Expand the payment program established under section 1.1(b) of this chapter to include all hospitals described in subsection (a).~~

~~(2)~~ **(1)** Establish a nominal charge hospital payment program.

~~(3)~~ **(2)** Establish any other permissible payment program.

(c) A program expanded or established under this section is subject to the availability of:

(1) intergovernmental transfers; ~~or~~

(2) funds certified as being eligible for federal financial participation; **or**

(3) other permissible sources of non-federal share dollars.

(d) The office may not implement a program under this section until the federal Centers for Medicare and Medicaid Services approves the provisions regarding the program in the amended state plan for medical assistance.

(e) The office may determine not to continue to implement a program established under this section if federal financial participation is not available.

SECTION 12. IC 12-15-19-2.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2.1. (a) For each state fiscal year ending on or after June 30, 2000, the office shall develop a disproportionate share payment methodology that ensures that each hospital qualifying for disproportionate share payments under IC 12-15-16-1(a) timely receives total disproportionate share payments that do not exceed the hospital's hospital specific limit provided under 42 U.S.C. 1396r-4(g). The payment methodology as developed by the office must:

(1) maximize disproportionate share hospital payments to qualifying hospitals to the extent practicable;

(2) take into account the situation of those qualifying hospitals that have historically qualified for Medicaid disproportionate share payments; and

(3) ensure that payments net of intergovernmental transfers made by or on behalf of qualifying hospitals are equitable.

(b) Total disproportionate share payments to a hospital under this chapter shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year shall be determined by the office taking into account data provided by each hospital that is considered reliable by the office based on a system of periodic audits, the use of trending factors, and an appropriate base year determined by the office. The office may require independent certification of data provided by a hospital to determine the hospital's hospital specific limit.

(c) The office shall include a provision in each amendment to the state plan regarding Medicaid disproportionate share payments that the office submits to the federal Centers for Medicare and Medicaid Services that, as provided in 42 CFR 447.297(d)(3), allows the state to make additional disproportionate share expenditures after the end of each federal fiscal year that relate back to a prior federal fiscal year. However, the total disproportionate share payments to:

(1) each individual hospital; and

(2) all qualifying hospitals in the aggregate;

may not exceed the limits provided by federal law and regulation.

(d) ~~The office shall, in each state fiscal year, provide sufficient funds for acute care hospitals licensed under IC 16-21 that qualify for disproportionate share payments under IC 12-15-16-1(a). Funds provided under this subsection:~~

~~(1) do not include funds transferred by other governmental units to the Medicaid indigent care trust fund; and~~

~~(2) must be in an amount equal to the amount that results from the following calculation:~~

~~STEP ONE: Multiply twenty-six million dollars ($26,000,000) by the federal medical assistance percentage.~~

~~STEP TWO: Subtract the amount determined under STEP ONE from twenty-six million dollars ($26,000,000).~~

A hospital that receives a payment under clause (B) of STEP FIVE of IC 12-15-15-1.5(c) is not eligible for a disproportionate share payment under this section.

SECTION 13. IC 12-15-19-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 6. (a) The office is not required to make disproportionate share payments under this chapter from the Medicaid indigent care trust fund established by IC 12-15-20-1 until the fund has received sufficient deposits to permit the office to make the state's share of the required disproportionate share payments.

(b) If:

(1) sufficient deposits have not been received; **or**

(2) the statewide Medicaid disproportionate share allocation is not sufficient to provide federal financial participation for the entirety of all eligible disproportionate share hospitals' specific limits;

the office ~~shall~~ **may** reduce disproportionate share payments **under IC 12-15-19-2.1** to ~~all~~ eligible institutions by ~~the same~~ **a** percentage **as long as, for each state fiscal year beginning after June 30, 2006, a hospital established under IC 16-22-8 receives at least sixty percent (60%) of the hospital's remaining hospital specific limit for each state fiscal year.** The percentage reduction shall be sufficient to ensure that payments do not exceed the **statewide Medicaid disproportionate share allocation or the** amounts that can be financed with the ~~state~~ **non-federal** share that is in the fund, **intergovernmental transfers, certifications of public expenditures, or other permissible sources of non-federal match.**

SECTION 14. IC 12-15-19-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 8. (a) A provider that qualifies as a municipal disproportionate share provider under IC 12-15-16-1 shall receive a disproportionate share adjustment, subject to the provider's hospital specific limits described in subsection (b) **and the total amount available for municipal disproportionate share payments in subsection (d),** as follows:

(1) For each state fiscal year ending on or after June 30, 1998, an amount shall be distributed to each provider qualifying as a municipal disproportionate share provider under IC 12-15-16-1. The total amount distributed shall not exceed the sum of all hospital specific limits for all qualifying providers.

(2) For each municipal disproportionate share provider qualifying under IC 12-15-16-1 to receive disproportionate share payments, the amount in subdivision (1) shall be reduced by ~~the amount of disproportionate share payments received by the provider under IC 12-15-16-6 or sections 1 or 2.1 of this chapter.~~ **all Medicaid payments, including Medicaid supplemental payments and other Medicaid disproportionate share payments received by the provider.** The office shall develop a disproportionate share provider payment methodology that ensures that each municipal disproportionate share provider receives disproportionate share payments that do not exceed the provider's hospital specific limit specified in subsection (b). The methodology developed by the office shall ensure that a municipal disproportionate share provider receives, to the extent possible, disproportionate share

payments that, when combined with any other ~~disproportionate share~~ **Medicaid supplemental** payments owed to the provider, ~~equals~~ **do not exceed** the provider's hospital specific limits.

(b) Total disproportionate share payments to a provider under this chapter and IC 12-15-16 shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for state fiscal years ending on or before June 30, 1999, shall be determined by the office taking into account data provided by each hospital for the hospital's most recent fiscal year or, if a change in fiscal year causes the most recent fiscal period to be less than twelve (12) months, twelve (12) months of data compiled to the end of the provider's fiscal year that ends within the most recent state fiscal year, as certified to the office by an independent certified public accounting firm. The hospital specific limit for all state fiscal years ending on or after June 30, 2000, shall be determined by the office taking into account data provided by each hospital that is deemed reliable by the office based on a system of periodic audits, the use of trending factors, and an appropriate base year determined by the office. The office may require independent certification of data provided by a hospital to determine the hospital's hospital specific limit.

(c) For each of the state fiscal years:

(1) beginning July 1, 1998, and ending June 30, 1999; and

(2) beginning July 1, 1999, and ending June 30, 2000;

the total municipal disproportionate share payments available under this section to qualifying municipal disproportionate share providers is twenty-two million dollars ($22,000,000).

(d) For each of the state fiscal years ending after June 30, 2006, the total municipal disproportionate share payments available under this section to qualifying municipal disproportionate share providers may not exceed thirty-five million dollars ($35,000,000).

SECTION 15. IC 12-15-19-10, AS AMENDED BY P.L.2-2005, SECTION 49, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 10. For state fiscal years beginning after June 30, 2000, **and ending June 30, 2003**, the state shall pay providers as follows:

(1) The state shall make municipal disproportionate share provider payments to providers qualifying under IC 12-15-16-1(b) until the state exceeds the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)).

(2) After the state makes all payments under subdivision (1), if the state fails to exceed the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)), the state shall make

disproportionate share provider payments to providers qualifying under IC 12-15-16-1(a).

(3) After the state makes all payments under subdivision (2), if the state fails to exceed the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)), or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)), the state shall make community mental health center disproportionate share provider payments to providers qualifying under IC 12-15-16-1(c).

SECTION 16. IC 12-15-20-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. The Medicaid indigent care trust fund is established to pay the non-federal share of the following:

(1) Enhanced disproportionate share payments to providers under IC 12-15-19-1.

(2) Subject to subdivision (8), disproportionate share payments to providers under IC 12-15-19-2.1.

(3) Medicaid payments for pregnant women described in IC 12-15-2-13 and infants and children described in IC 12-15-2-14.

(4) Municipal disproportionate share payments to providers under IC 12-15-19-8.

(5) Payments to hospitals under IC 12-15-15-9.

(6) Payments to hospitals under IC 12-15-15-9.5.

(7) Payments, funding, and transfers as otherwise provided in clauses (8)(D), ~~and~~ (8)(F), **and (8)(G).**

(8) Of the intergovernmental transfers deposited into the Medicaid indigent care trust fund, the following apply:

(A) The entirety of the intergovernmental transfers deposited into the Medicaid indigent care trust fund for state fiscal years ending on or before June 30, 2000, shall be used to fund the state's share of the disproportionate share payments to providers under IC 12-15-19-2.1.

(B) Of the intergovernmental transfers deposited into the Medicaid indigent care trust fund for the state fiscal year ending June 30, 2001, an amount equal to one hundred percent (100%) of the total intergovernmental transfers deposited into the Medicaid indigent care trust fund for the state fiscal year beginning July 1, 1998, and ending June 30, 1999, shall be used to fund the state's share of disproportionate share payments to providers under IC 12-15-19-2.1. The remainder of the intergovernmental transfers, if any, for the state fiscal

year shall be used to fund the state's share of additional Medicaid payments to hospitals licensed under IC 16-21 pursuant to a methodology adopted by the office.

(C) Of the intergovernmental transfers deposited into the Medicaid indigent care trust fund, for state fiscal years beginning July 1, 2001, and July 1, 2002, an amount equal to:

(i) one hundred percent (100%) of the total intergovernmental transfers deposited into the Medicaid indigent care trust fund for the state fiscal year beginning July 1, 1998; minus

(ii) an amount equal to the amount deposited into the Medicaid indigent care trust fund under IC 12-15-15-9(d) for the state fiscal years beginning July 1, 2001, and July 1, 2002;

shall be used to fund the state's share of disproportionate share payments to providers under IC 12-15-19-2.1. The remainder of the intergovernmental transfers, if any, must be used to fund the state's share of additional Medicaid payments to hospitals licensed under IC 16-21 pursuant to a methodology adopted by the office.

(D) Of the intergovernmental transfers, which shall include amounts transferred under IC 12-16-7.5-4.5(b), STEP FOUR, deposited into the Medicaid indigent care trust fund for state fiscal years ending after June 30, 2003, **but before July 1, 2005,** an amount equal to:

(i) one hundred percent (100%) of the total intergovernmental transfers deposited into the Medicaid indigent care trust fund for the state fiscal year beginning July 1, 1998, and ending June 30, 1999; minus

(ii) an amount equal to the amount deposited into the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) for the state fiscal year ending after June 30, 2003;

shall be used to fund the non-federal share of disproportionate share payments to providers under IC 12-15-19-2.1. The remainder of the intergovernmental transfers, if any, for the state fiscal years shall be used to fund, in descending order of priority, the non-federal share of payments to hospitals under IC 12-15-15-9, the non-federal share of payments to hospitals under IC 12-15-15-9.5, the amount to be transferred under clause (F), and the non-federal share of payments under clauses (A) and (B) of STEP FIVE of IC 12-15-15-1.5(b).

(E) The total amount of intergovernmental transfers used to fund the non-federal share of payments to hospitals under IC 12-15-15-9 and IC 12-15-15-9.5 shall not exceed the amount calculated under STEP TWO of the following formula:

STEP ONE: Calculate the total amount of funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP TWO: Multiply the state Medicaid medical assistance percentage for the state fiscal year for which the payments under IC 12-15-15-9 and IC 12-15-15-9.5 are to be made by the amount calculated under STEP ONE.

(F) As provided in clause (D), for each fiscal year ending after June 30, 2003, **but before July 1, 2005,** an amount equal to the amount calculated under STEP THREE of the following formula shall be transferred to the office:

STEP ONE: Calculate the product of thirty-five million dollars ($35,000,000) multiplied by the federal medical assistance percentage for federal fiscal year 2003.

STEP TWO: Calculate the sum of the amounts, if any, reasonably estimated by the office to be transferred or otherwise made available to the office for the state fiscal year, and the amounts, if any, actually transferred or otherwise made available to the office for the state fiscal year, under arrangements whereby the office and a hospital licensed under IC 16-21-2 agree that an amount transferred or otherwise made available to the office by the hospital or on behalf of the hospital shall be included in the calculation under this STEP.

STEP THREE: Calculate the amount by which the product calculated under STEP ONE exceeds the sum calculated under STEP TWO.

(G) For each fiscal year ending after June 30, 2005, the total amount of intergovernmental transfers deposited into the Medicaid indigent care trust fund shall be used as follows:

(1) Thirty million dollars ($30,000,000) shall be transferred to the office for the Medicaid budget.

(2) An amount not to exceed eleven million six hundred fifty thousand dollars ($11,650,000) to fund the non-federal share of payments to hospitals under IC 12-15-15-9 and IC 12-15-15-9.5.

(3) An amount not to exceed eight million nine hundred seventy-five thousand dollars ($8,975,000) to fund the

non-federal share of payments to hospitals made under clause (A) of STEP FIVE of IC 12-15-15-1.5(c).

(4) To fund the non-federal share of payments to hospitals made under clause (B) of STEP FIVE of IC 12-15-15-1.5(c).

(5) To fund the non-federal share of payments to hospitals made under clause (C) of STEP FIVE of IC 12-15-15-1.5(c).

(6) To fund the non-federal share of disproportionate share payments to hospitals under IC 12-15-19-2.1.

(7) If additional funds are available after making payments under subdivisions (1) through (6), to fund other Medicaid supplemental payments for hospitals approved by the office and included in the state Medicaid plan.

SECTION 17. IC 12-15-20.7-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. **(a)** For each state fiscal year **ending before July 1, 2005,** subject to section 3 of this chapter, the office shall make the payments identified in this section in the following order:

(1) First, payments under IC 12-15-15-9 and IC 12-15-15-9.5.

(2) Second, payments under clauses (A) and (B) of STEP FIVE of IC 12-15-15-1.5(b).

(3) Third, Medicaid inpatient payments for safety-net hospitals and Medicaid outpatient payments for safety-net hospitals.

(4) Fourth, payments under IC 12-15-15-1.1 and 12-15-15-1.3.

(5) Fifth, payments under IC 12-15-19-8 for municipal disproportionate share hospitals.

(6) Sixth, payments under IC 12-15-19-2.1 for disproportionate share hospitals.

(7) Seventh, payments under clause (C) of STEP FIVE of IC 12-15-15-1.5(b).

(b) For each state fiscal year ending after June 30, 2005, subject to section 3 of this chapter, the office shall make the payments identified in this section in the following order:

(1) First, the payment under IC 12-15-20-2(8)(G)(1).

(2) Second, payments under IC 12-15-15-1.1 and IC 12-15-15-1.3.

(3) Third, payments under IC 12-15-19-8.

(4) Fourth, payments under IC 12-15-15-9 and IC 12-15-15-9.5.

(5) Fifth, payments under clause (A) of STEP FIVE of IC 12-15-15-1.5(c).

(6) Sixth, payments under clause (B) of STEP FIVE of IC 12-15-15-1.5(c).

(7) Seventh, payments under clause (C) of STEP FIVE of IC 12-15-15-1.5(c).

(8) Eighth, payments under clause (D) of STEP FIVE of IC 12-15-15-1.5(c).

(9) Ninth, payments under IC 12-15-19-2.1 for disproportionate share hospitals.

SECTION 18. IC 12-15-44 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

Chapter 44. Healthier Indiana Insurance Program

Sec. 1. As used in this chapter, "custodial parent" means the individual with whom a child resides and who is related to the child in one (1) of the following manners:

(1) Legal or biological mother.

(2) Legal or biological father.

(3) A blood relative within the fifth degree of relation, including an individual who is related by half blood.

(4) Stepfather, stepmother, stepbrother, or stepsister.

(5) An individual who legally adopts a child or the child's parent, as well as relatives of the adoptive parents.

(6) Legal spouses of an individual described in this subsection.

Sec. 2. As used in this chapter, "preventative care services" means care that is provided to an individual for the purpose of preventing disease, diagnosing disease, or promoting good health.

Sec. 3. As used in this chapter, "program" refers to the healthier Indiana insurance program established by IC 12-15-44-4.

Sec. 4. (a) The healthier Indiana insurance program is established.

(b) The office shall administer the program. The department of insurance and the office of the secretary shall provide oversight on the marketing practices of the program.

(c) The following requirements apply to funds appropriated by the general assembly to the program:

(1) At least ninety percent (90%) must be used to fund payment for health care services.

(2) Not more than ten percent (10%) may be used to fund:

(A) administrative costs; and

(B) any profit derived from a contract entered into by a person to provide services for the program.

(d) The program must include the following in a manner and to the extent determined by the office:

(1) Mental health care services.

(2) Inpatient hospital services.
(3) Prescription drug coverage.
(4) Emergency room services.
(5) Physician office services.
(6) Diagnostic services.
(7) Outpatient services, including therapy services.
(8) Disease management.
(9) Home health services.
(10) Urgent care center services.

Sec. 5. (a) An individual is eligible for the program if the individual meets the following requirements:

(1) The individual is at least eighteen (18) years of age and less than sixty-five (65) years of age.
(2) The individual is a United States citizen and has been a resident of Indiana for at least twelve (12) months.
(3) The individual has an annual household income of:
(A) not more than two hundred percent (200%) of the federal income poverty level if the individual is a custodial parent; or
(B) at least one hundred percent (100%) and not more than two hundred percent (200%) of the federal income poverty level if the individual is not a custodial parent.
(4) The individual is not eligible for health insurance coverage through the individual's employer.
(5) The individual has not had health insurance coverage for at least six (6) months.

(b) The following individuals are not eligible for this program:

(1) An individual who participates in the federal Medicare program (42 U.S.C. 1395 et seq.).
(2) A pregnant woman for purposes of pregnancy related services.
(3) An individual who is eligible for the Medicaid program as a disabled person.

Sec. 6. (a) In order to participate in the program, an individual shall do the following:

(1) Apply for the program on a form prescribed by the office. The office may develop and allow a joint application for a household.
(2) If the individual is approved by the office to participate in the program, contribute to the individual's health care account:
(A) at least one thousand one hundred dollars ($1,100) per

year, but not more than five percent (5%) of the individual's annual household income; or

(B) one thousand one hundred dollars ($1,100) per year less the individual's contributions to the Medicaid program under IC 12-15, the children's health insurance program under IC 12-17.6, or the Medicare program (42 U.S.C. 1395 et seq.), as determined by the office.

(b) The state shall contribute the difference into the individual's account if the individual's contribution of five percent (5%) of the individual's annual income is less than the required one thousand one hundred dollars ($1,100).

(c) If the individual does not make the individual's contributions to the program within thirty (30) days of the required payment, the individual may be terminated from participating in the program. The individual shall receive written notice before the individual is terminated from the program.

(d) After termination from the program under subsection (c), the individual may not reapply to participate in the program for eighteen (18) months.

(e) An individual may be held responsible under the program for receiving nonemergency services in an emergency room setting. This may include requiring the individual to pay for services received in the emergency room with money outside the individual's health care account.

Sec. 7. (a) A participant must have a health care account in which contributions are made by the participant, an employer, or the office.

(b) The minimum amount in the account is the amount contributed by the individual and the state as described in section 6 of this chapter.

(c) The account is to be used for paying the individual's deductible for health care services in the program.

(d) The individual may contribute to the individual's health care account through the following means:

(1) By the employer withholding or causing to be withheld from the participating employee's wages or salary, after taxes are taken out of the wages or salary, the participating employee's required share described in this chapter and distributed equally throughout the calendar year.

(2) By submitting the individual's required share to the office to deposit into the individual's account in a manner prescribed by the office.

(3) Any other means determined by the office.

(e) An employer may not contribute more than fifty percent (50%) of the individual's required share to the health care account.

Sec. 8. (a) The program must cover preventative care services, as determined by the office, for a participant of not more than five hundred dollars ($500) per year. This amount shall be paid by the state at no cost to the participant.

(b) The office shall provide a participant with a list of health care services that will qualify as preventative care services for the age, gender, and preexisting conditions of the participant. The office shall consult the federal Centers for Disease Control and Prevention for a list of recommended preventative care services.

Sec. 9. (a) The office shall determine the health care services covered under the program.

(b) The program is not an entitlement program, and the number of individuals who may participate in the program is dependent upon the funds appropriated for use for the plan.

Sec. 10. The program has the following per recipient coverage limitations:

(1) An annual individual maximum coverage limitation of three hundred thousand dollars ($300,000).

(2) A lifetime individual maximum coverage of one million dollars ($1,000,000).

Sec. 11. (a) An individual who is approved to participate in the program is eligible for a twelve (12) month period. Once the individual has been approved for participation, the individual may not be turned down for renewal into the program for the sole reason that the program has reached the maximum number of participants.

(b) If the individual chooses to renew participation in the program, the individual shall complete a renewal application, any necessary documentation, and submit the documentation and application on a form prescribed by the office to the office in order to continue participating in the program.

(c) If the individual chooses not to renew participation in the program, the individual may not reapply to participate in the program for at least eighteen (18) months.

Sec. 12. (a) An insurer or health maintenance organization that has contracted with the office to provide health insurance for individuals under this program:

(1) bears the risk of the health insurance program;

(2) is responsible for the claim processing under the program;

(3) shall reimburse providers at a reimbursement rate of:

(A) at least the federal Medicare reimbursement rate for the service provided; or

(B) at a rate of one hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate; and

(4) may not deny coverage to an eligible individual who has been approved by the office to participate in the program, except if the maximum coverage rates are met as described in section 10 of this chapter.

(b) An insurer or a health maintenance organization that has contracted with the office to provide health insurance under the program shall also offer to provide the same health insurance to the following:

(1) An individual who has an annual household income that is:

(A) not more than two hundred percent (200%) of the federal income poverty level but the individual is not eligible for the program because of the individual's income or because a slot is not available for the individual; or

(B) more than two hundred percent (200%) of the federal income poverty level.

(2) The employees of an employer if:

(A) the employees have an annual household income that is more than two hundred percent (200%) of the federal income poverty level; and

(B) the employer:

(i) has not offered employees health care insurance in the previous twelve (12) months; and

(ii) pays at least fifty percent (50%) of the premium for the employer's employees.

The state does not provide funding for coverage provided under this subsection.

Sec. 13. (a) A participant in the program has coverage for a period of twelve (12) months. If the participant would like to continue participating in the program, the participant must submit an application for renewal with the office as required in section 11 of this chapter.

(b) At the end an individual's twelve (12) month program period, and if the individual's health care account contains a balance of more than five hundred dollars ($500), the individual may withdraw the money that exceeds five hundred dollars ($500) from the account if the criteria specified in subsection (c) are met.

(c) The individual may only withdraw money from the individual's health care account if the following criteria are met:

(1) The account has more than five hundred dollars ($500) remaining.

(2) The money being withdrawn is money that the individual, not the state, contributed to the account and may not exceed the total of the individual's contribution. The office shall determine this amount by prorating the remaining amount with the amount contributed by the individual.

(3) The individual has completed the individual's preventative care services.

(4) Either:

(A) the individual is no longer eligible for the program because the individual's annual household income exceeds the amounts set forth in section 5(a)(3) of this chapter; or

(B) the money is used to pay for dental services or vision services that are not covered under the program's plan.

(d) Money remaining in the account at the end of the individual's twelve (12) month period that is not withdrawn as allowed under subsection (c):

(1) remains in the account if the individual renews participation in the program and the amount the individual needs to contribute to the account in the following program year is prorated based on the amount remaining in the account; or

(2) is forfeited by the individual and reverts back to the state for deposit in the healthier Indiana insurance fund if the individual:

(A) does not continue to participate in the program; or

(B) is terminated from the program under section 6 of this chapter.

Sec. 14. (a) The healthier Indiana insurance fund is established for the following purposes:

(1) Administering a program created by the general assembly to provide health insurance for low income residents of the state under this chapter.

(2) Providing copayments, preventative care services, and premiums for individuals enrolled in the program.

(3) Funding tobacco use prevention and cessation programs and programs designed to promote the general health and well being of Indiana residents.

(4) Promoting research in the health and life sciences field,

including grants to universities for operating and capital expenses.

The fund is apart from the state general fund.

(b) The fund shall be administered by the office of the secretary of family and social services.

(c) The expenses of administering the fund shall be paid from money in the fund.

(d) The fund shall consist of the following:

(1) Cigarette tax revenues and tobacco products tax revenues designated by the general assembly to be part of the fund.

(2) Other funds designated by the general assembly to be part of the fund.

(3) Federal funds available for the purposes of the fund.

(4) Gifts or donations to the fund.

(e) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public money may be invested.

(f) Money must be appropriated before funds are available for use.

(g) Money in the fund does not revert to the state general fund at the end of any fiscal year.

Sec. 15. (a) The office may not:

(1) enroll applicants;

(2) approve any contracts with vendors to provide services or administer the program;

(3) incur costs other than those necessary to study and plan for the implementation of the program; or

(4) create financial obligations for the state;

unless both of the conditions of subsection (b) are satisfied.

(b) The office may not take any action described in subsection (a) unless:

(1) there is a specific appropriation from the general assembly to implement the program; and

(2) after review by the budget committee, the budget agency approves an actuarial analysis that demonstrates sufficient funding is reasonably estimated to be available to operate the program for at least the following eight (8) years.

The actuarial analysis under subdivision (2) must clearly indicate the cost and revenue assumptions used in reaching the determination.

(c) The office may not operate the program in a way that would obligate the state to financial participation beyond the level of state

appropriations authorized for this purpose.

(d) The office shall:

(1) modify limitations on participation;

(2) modify services provided;

(3) establish or modify copayments; or

(4) otherwise limit program expansion;

in order to manage the program within the spending authorized by the general assembly.

Sec. 16. The office may adopt rules under IC 4-22-2 necessary to implement this chapter. The office may adopt emergency rules under IC 4-22-2-37.1 to implement the program on an emergency basis.

SECTION 19. IC 12-16-7.5-4.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4.5. (a) Not later than October 31 following the end of each state fiscal year, the division shall:

(1) calculate for each county the total amount of payable claims submitted to the division during the state fiscal year attributed to:

(A) patients who were residents of the county; and

(B) patients:

(i) who were not residents of Indiana;

(ii) whose state of residence could not be determined by the division; and

(iii) who were residents of Indiana but whose county of residence in Indiana could not be determined by the division;

and whose medical condition that necessitated the care or service occurred in the county;

(2) notify each county of the amount of payable claims attributed to the county under the calculation made under subdivision (1); and

(3) with respect to payable claims attributed to a county under subdivision (1):

(A) calculate the total amount of payable claims submitted during the state fiscal year for:

(i) each hospital;

(ii) each physician; and

(iii) each transportation provider; and

(B) determine the amount of each payable claim for each hospital, physician, and transportation provider listed in clause (A).

(b) Before November 1 following the end of a state fiscal year, the

division shall allocate the funds transferred from a county's hospital care for the indigent fund to the state hospital care for the indigent fund under IC 12-16-14 during or for the state fiscal year as required under the following STEPS:

STEP ONE: Determine the total amount of funds transferred from a county's hospital care for the indigent fund by the county to the state hospital care for the indigent fund under IC 12-16-14 during or for the state fiscal year.

STEP TWO: Of the total amount of payable claims submitted to the division during the state fiscal year attributed to the county under subsection (a), determine the amount of total hospital payable claims, total physician payable claims, and total transportation provider payable claims. Of the amounts determined for physicians and transportation providers, calculate the sum of those amounts as a percentage of an amount equal to the sum of the total payable physician claims and total payable transportation provider claims attributed to all the counties submitted to the division during the state fiscal year.

STEP THREE: Multiply three million dollars ($3,000,000) by the percentage calculated under STEP TWO.

STEP FOUR: Transfer to the Medicaid indigent care trust fund for purposes of IC 12-15-20-2(8)(D) **or IC 12-15-20-2(8)(G)** an amount equal to the amount calculated under STEP ONE, minus an amount equal to the amount calculated under STEP THREE.

STEP FIVE: The division shall retain an amount equal to the amount remaining in the state hospital care for the indigent fund after the transfer in STEP FOUR for purposes of making payments under section 5 of this chapter.

(c) The costs of administering the hospital care for the indigent program, including the processing of claims, shall be paid from the funds transferred to the state hospital care for the indigent fund.

SECTION 20. IC 12-16-14-3, AS AMENDED BY P.L.246-2005, SECTION 111, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 3. ~~(a) For purposes of this section, "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).~~

~~(b)~~ **(a)** For taxes first due and payable in 2003, each county shall impose a hospital care for the indigent property tax levy equal to the product of:

(1) the county's hospital care for the indigent property tax levy for taxes first due and payable in 2002; multiplied by

(2) the county's assessed value growth quotient determined under IC 6-1.1-18.5-2 for taxes first due and payable in 2003.

~~(c)~~ **(b)** For taxes first due and payable in 2004, ~~2005, 2006, 2007, and 2008,~~ **and each year thereafter,** each county shall impose a hospital care for the indigent property tax levy equal to the ~~product of:~~ **hospital care for the indigent program property tax levy for taxes first due and payable in the preceding calendar year.**

~~(1) the county's hospital care for the indigent property tax levy for taxes first due and payable in the preceding year; multiplied by~~

~~(2) the assessed value growth quotient determined in the last STEP of the following STEPS:~~

~~STEP ONE: Determine the three (3) calendar years that most immediately precede the ensuing calendar year and in which a statewide general reassessment of real property does not first become effective:~~

~~STEP TWO: Compute separately, for each of the calendar years determined in STEP ONE, the quotient (rounded to the nearest ten-thousandth) of the county's total assessed value of all taxable property in the particular calendar year, divided by the county's total assessed value of all taxable property in the calendar year immediately preceding the particular calendar year.~~

~~STEP THREE: Divide the sum of the three (3) quotients computed in STEP TWO by three (3).~~

~~(d) Except as provided in subsection (e):~~

~~(1) for taxes first due and payable in 2009, each county shall impose a hospital care for the indigent property tax levy equal to the average of the annual amount of payable claims attributed to the county under IC 12-16-7.5-4.5 during the state fiscal years beginning:~~

~~(A) July 1, 2005;~~

~~(B) July 1, 2006; and~~

~~(C) July 1, 2007; and~~

~~(2) for all subsequent annual levies under this section, the average annual amount of payable claims attributed to the county under IC 12-16-7.5-4.5 during the three (3) most recently completed state fiscal years.~~

~~(e) A county may not impose an annual levy under subsection (d) in an amount greater than the product of:~~

~~(1) The greater of:~~

~~(A) the county's hospital care for the indigent property tax levy for taxes first due and payable in 2008; or~~

~~(B) the amount of the county's maximum hospital care for the indigent property tax levy determined under this subsection for taxes first due and payable in the immediately preceding year;~~

~~multiplied by~~

~~(2) the assessed value growth quotient determined in the last STEP of the following STEPS:~~

~~STEP ONE: Determine the three (3) calendar years that most immediately precede the ensuing calendar year and in which a statewide general reassessment of real property does not first become effective.~~

~~STEP TWO: Compute separately, for each of the calendar years determined in STEP ONE, the quotient (rounded to the nearest ten-thousandth) of the county's total assessed value of all taxable property in the particular calendar year, divided by the county's total assessed value of all taxable property in the calendar year immediately preceding the particular calendar year.~~

~~STEP THREE: Divide the sum of the three (3) quotients computed in STEP TWO by three (3).~~

SECTION 21. IC 27-8-5-16 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 16. Except as provided in sections 17 and 24 of this chapter, no policy of group accident and sickness insurance may be delivered or issued for delivery to a group that has a legal situs in Indiana unless it conforms to one (1) of the following descriptions:

(1) A policy issued to an employer or to the trustees of a fund established by an employer (which employer or trustees must be deemed the policyholder) to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(A) The employees eligible for insurance under the policy must be all of the employees of the employer, or all of any class or classes of employees. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, members, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" includes elected or appointed officials.

(B) The premium for the policy must be paid either from the

employer's funds, from funds contributed by the insured employees, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(2) A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two (2) or more creditors (which creditor, holding company, affiliate, trustee, trustees, or agent must be deemed the policyholder) to insure debtors of the creditor, or creditors, subject to the following requirements:

(A) The debtors eligible for insurance under the policy must be all of the debtors of the creditor or creditors, or all of any class or classes of debtors. The policy may provide that the term "debtors" includes:

(i) borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(ii) the debtors of one (1) or more subsidiary corporations; and

(iii) the debtors of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the policyholder and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control.

(B) The premium for the policy must be paid either from the creditor's funds, from charges collected from the insured debtors, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from the funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

(C) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

(D) The amount of the insurance payable with respect to any indebtedness may not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments that are delinquent on the date the debtor becomes disabled as defined in the policy.

(E) The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. Each payment under this clause must reduce or extinguish the unpaid indebtedness of the debtor to the extent of the payment, and any excess of the insurance must be payable to the insured or the estate of the insured.

(F) Notwithstanding clauses (A) through (E), insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan, and insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

(3) A policy issued to a labor union or similar employee organization (which must be deemed to be the policyholder) to insure members of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

(A) The members eligible for insurance under the policy must be all of the members of the union or organization, or all of any class or classes of members.

(B) The premium for the policy must be paid either from funds of the union or organization, from funds contributed by the insured members specifically for their insurance, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(4) A policy issued to a trust or to one (1) or more trustees of a fund established or adopted by two (2) or more employers, or by one (1) or more labor unions or similar employee organizations, or by one (1) or more employers and one (1) or more labor unions or similar employee organizations (which trust or trustees must be deemed the policyholder) to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(A) The persons eligible for insurance must be all of the

employees of the employers or all of the members of the unions or organizations, or all of any class or classes of employees or members. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. The policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with the trusteeship.

(B) The premium for the policy must be paid from funds contributed by the employer or employers of the insured persons, by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and one (1) or more employers, unions, or similar employee organizations. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(5) A policy issued to an association or to a trust or to one (1) or more trustees of a fund established, created, or maintained for the benefit of members of one (1) or more associations. The association or associations must have at the outset a minimum of one hundred (100) persons, must have been organized and maintained in good faith for purposes other than that of obtaining insurance, must have been in active existence for at least one (1) year, and must have a constitution and bylaws that provide that the association or associations hold regular meetings not less than annually to further purposes of the members, that, except for credit unions, the association or associations collect dues or solicit contributions from members, and that the members have voting privileges and representation on the governing board and

committees. The policy must be subject to the following requirements:

(A) The policy may insure members or employees of the association or associations, employees of members, one (1) or more of the preceding, or all of any class or classes of members, employees, or employees of members for the benefit of persons other than the employee's employer.

(B) The premium for the policy must be paid from funds contributed by the association or associations, by employer members, or by both, from funds contributed by the covered persons, or from both the covered persons and the association, associations, or employer members.

(C) Except as provided in clause (D), a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for the insurance must insure all eligible persons, except those who reject such coverage in writing.

(D) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(6) A policy issued to a credit union, or to one (1) or more trustees or an agent designated by two (2) or more credit unions (which credit union, trustee, trustees, or agent must be deemed the policyholder) to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee, trustees, or agent, or any of their officials, subject to the following requirements:

(A) The members eligible for insurance must be all of the members of the credit union or credit unions, or all of any class or classes of members.

(B) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in clause (C), must insure all eligible members.

(C) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

(7) A policy issued to cover persons in a group specifically described by another law of Indiana as a group that may be covered for group life insurance. The provisions of the group life insurance law relating to eligibility and evidence of insurability apply to a group health policy to which this subdivision applies.

(8) A policy issued to a trustee or agent designated by two (2)

or more small employers (as defined in IC 27-8-15-14) as determined by the commissioner under rules adopted under IC 4-22-2.

SECTION 22. IC 27-8-5-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 17. (a) A group accident and sickness insurance policy shall not be delivered or issued for delivery in Indiana to a group that is not described in section 16(1)(A), 16(2)(A), 16(3)(A), 16(4)(A), 16(5)(A), 16(6)(A), ~~or~~ 16(7), **or 16(8)** of this chapter unless the commissioner finds that:

(1) the issuance of the policy is not contrary to the best interest of the public;

(2) the issuance of the policy would result in economies of acquisition or administration; and

(3) the benefits of the policy are reasonable in relation to the premiums charged.

(b) Except as otherwise provided in this chapter, an insurer may exclude or limit the coverage under a policy described in subsection (a) on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

SECTION 23. IC 27-8-10.1 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

Chapter 10.1. High Risk Hoosiers Under the Healthier Indiana Insurance Program

Sec. 1. As used in this chapter, "association" means the Indiana comprehensive health insurance association established by IC 27-8-10-2.1.

Sec. 2. As used in this chapter, "covered individual" means an individual entitled to coverage under the program.

Sec. 3. As used in this chapter, "program" refers to the healthier Indiana insurance program established by IC 12-15-44-4.

Sec. 4. (a) The association shall administer the program for individuals who are referred to the association by the office of the secretary of family and social services.

(b) Coverage under the program is separate from the coverage provided under IC 27-8-10.

(c) The following apply to the administration of the program under this chapter:

(1) Only individuals referred by the office of the secretary of family and social services are eligible for program coverage administered under this chapter.

(2) Program coverage administered under this chapter must

provide medical management services.

(d) A covered individual shall participate in medical management services provided under this chapter.

SECTION 24. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.**

(b) The office shall apply to the United States Department of Health and Human Services for approval of a Section 1115 demonstration waiver to develop and implement a health insurance program to cover individuals who meet the following requirements:

(1) The individual is at least eighteen (18) years of age and less than sixty-five (65) years of age.

(2) The individual is a United States citizen and has been a resident of Indiana for at least twelve (12) months.

(3) The individual has an annual household income of:

(A) not more than two hundred percent (200%) of the federal income poverty level if the individual is a custodial parent; or

(B) at least one hundred percent (100%) and not more than two hundred percent (200%) of the federal income poverty level if the individual is not a custodial parent.

(4) The individual is not eligible for health insurance coverage through the individual's employer.

(5) The individual has been without health insurance coverage for at least six (6) months or is without health insurance coverage because of a change in employment.

(c) The office shall include in the waiver application a request to fund the program in part by using:

(1) costs not otherwise matchable dollars; and

(2) hospital care for the indigent dollars, upper payment limit dollars, or disproportionate share hospital dollars.

(d) The office may not implement the waiver until the office:

(1) files an affidavit with the governor attesting that the federal waiver applied for under this SECTION is in effect; and

(2) has sufficient funding for the program.

The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the waiver is approved.

(e) The office may adopt rules under IC 4-22-2 necessary to implement this SECTION.

(f) This SECTION expires December 31, 2013.

SECTION 25. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.**

(b) The office shall apply to the United States Department of Health and Human Services for approval of an amendment to the state's Medicaid plan that is necessary to do the following:

(1) Amend the state's upper payment limit program.

(2) Make changes to the state's disproportionate share hospital program.

(c) The office may not implement an approved amendment to the state plan until the office files an affidavit with the governor attesting that the state plan amendment applied for under subsection (b)(1) or (b)(2) of this SECTION is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the state plan amendment is approved.

(d) The office may adopt rules under IC 4-22-2 necessary to implement this SECTION.

(e) This SECTION expires December 31, 2013.

SECTION 26. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "commission" refers to the health finance commission established by IC 2-5-23-3.**

(b) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(c) The office shall report to the commission during the 2007 interim, updating the commission on the status of the development and implementation of the healthier Indiana insurance program established by IC 12-15-44-4, as added by this act.

(d) This SECTION expires December 31, 2008.

SECTION 27. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "small employer" means any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.**

(b) The commissioner of the department of insurance and the office of the secretary of family and social services shall, not later

than January 1, 2008, implement a program to allow two (2) or more small employers to join together to purchase health insurance, as described in IC 27-8-5-16(8), as amended by this act.

(c) The commissioner shall adopt rules under IC 4-22-2 necessary to implement this SECTION.

SECTION 28. **An emergency is declared for this act.**

SENATE MOTION

Madam President: I move that Senator Simpson be added as second author of Senate Bill 503.

MILLER

SENATE MOTION

Madam President: I move that Senator Errington be added as coauthor of Senate Bill 503.

MILLER

SENATE MOTION

Madam President: I move that Senator Sipes be added as coauthor of Senate Bill 503.

MILLER

SENATE MOTION

Madam President: I move that Senator Becker be added as third author and Senator Rogers be added as coauthor of Senate Bill 503.

MILLER

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 503, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 6, line 36, strike "shortfall" and insert "**supplemental payment**".

Page 6, line 40, strike "Payment for a state fiscal year ending after

June 30,".

Page 6, strike line 41.

Page 6, line 42, strike "year's end.".

Page 7, line 9, strike "STEP SEVEN of".

Page 7, strike lines 10 through 12.

Page 7, line 13, strike "(b)." and insert "**this section.**".

Page 7, line 14, after "section" insert ".".

Page 7, line 14, strike "and as otherwise provided under".

Page 7, line 15, delete "IC 12-15-20-2(6).".

Page 7, line 17, strike "subsection (d)" and insert "**this section**".

Page 7, line 18, strike "STEP SEVEN of".

Page 7, line 22, strike "STEP".

Page 7, line 23, strike "SEVEN of".

Page 7, line 26, strike "STEP SEVEN of".

Page 7, line 32, strike "shortfall" and insert "**supplemental payment**".

Page 8, line 5, strike "shortfall" and insert "**supplemental payment**".

Page 9, line 16, strike "shortfall" and insert "**supplemental payment**".

Page 9, line 18, strike "Subject to subsection (e), the reimbursement for a state fiscal".

Page 9, strike line 19.

Page 9, line 20, strike "following the end of the state fiscal year.".

Page 9, line 22, strike "under subsection (d)." and insert "**by the hospital or on behalf of the hospital.**".

Page 9, line 29, strike "STEP SEVEN of".

Page 9, line 30, strike "In determining the percentage, the office shall apply the".

Page 9, strike lines 31 through 32.

Page 9, line 33, strike "(b).".

Page 9, line 34, after "section" insert "."

Page 9, line 34, strike "and as otherwise provided under".

Page 9, line 35, delete "IC 12-15-20-2(6).".

Page 9, line 37, strike "subsection (d)" and insert "**this section**".

Page 9, line 38, strike "STEP SEVEN of".

Page 9, line 42, strike "STEP".

Page 10, line 1, strike "SEVEN of".

Page 10, line 4, strike "STEP SEVEN of".

Page 10, line 10, strike "shortfall" and insert "**supplemental payment**".

Page 10, line 25, strike "shortfall" and insert "**supplemental**

payment".

Page 11, line 1, after "2003," insert "**and before July 1, 2005,**".

Page 11, line 27, reset in roman "IC 12-15-20-2(8)(D)".

Page 11, line 27, delete "**IC 12-15-20-2(6)(D)**".

Page 12, strike lines 18 through 21.

Page 12, between lines 21 and 22, begin a new paragraph and insert:

"**(c) For state fiscal years ending after July 1, 2005, in addition to reimbursement received under section 1 of this chapter, a hospital eligible under this section is entitled to reimbursement in an amount calculated as follows:**

STEP ONE: The office shall identify the total inpatient hospital services and the total outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by a hospital described in subsection (a).

STEP TWO: For the total inpatient hospital services and the total outpatient hospital services identified under STEP ONE, the office shall calculate the total payments made under this article and under the state Medicaid plan to a hospital described in subsection (a), excluding payments made under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the total amount that would have been paid by the office for the inpatient hospital services and the outpatient hospital services identified in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) Subject to the availability of funds under IC 12-15-20-2(7) to serve as the non-federal share of the payments, the amount calculated under STEP FOUR for a state fiscal year shall be paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis based on the hospitals' Medicaid inpatient days or, if the federal Centers for Medicare and Medicaid Services do not approve that methodology, another payment methodology approved by the federal Centers for Medicare and Medicaid Services. For purposes of this clause, a hospital's Medicaid inpatient days are the

hospital's in-state Medicaid paid claims and Medicaid managed care days for the state fiscal year referenced in STEP ONE, as determined by the office.

(B) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clause (A), the remaining amount shall be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause only if the hospital:

(i) has less than seventy thousand (70,000) Medicaid inpatient days annually;

(ii) was eligible for disproportionate share hospital payments under IC 12-15-19-2.1 for the state fiscal year ending June 30, 1998, or the hospital met the office's Medicaid disproportionate share payment criteria for payment under IC 12-15-19-2.1 based upon state fiscal year 1998 data and received a Medicaid disproportionate share payment for the state fiscal year ending June 30, 2001; and

(iii) received a Medicaid disproportionate share payment under IC 12-15-19-2.1 for state fiscal years 2001, 2002, 2003, and 2004.

The amount of a hospital's payment under this clause is subject to the extent that Medicaid indigent care trust funds are available or, if none are available, the non-federal share of the hospital's payment is provided by or on behalf of the hospital. The payment to each hospital shall equal the hospital's hospital specific limit provided under 42 U.S.C. 1396r-4 when the payments are combined with any other Medicaid payments made to the hospital. For state fiscal years ending before July 1, 2008, the total payments made under this clause may not exceed a total amount of sixty-eight million dollars ($68,000,000). For a state fiscal year ending after June 30, 2008, the total payments made under this clause may not exceed a total amount of sixty-eight million dollars ($68,000,000) plus the annual percentage growth in the state's aggregate Medicaid upper payment limit, as calculated by the office.

(C) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) and (B), the remaining amount may be paid to hospitals described in

subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause if the hospital:

(i) has less than seventy thousand (70,000) Medicaid inpatient days annually;

(ii) has received or is eligible to receive Medicaid disproportionate share payments under IC 12-15-19-2.1 for state fiscal years 2002, 2003, 2004, and for each state fiscal year after 2004; and

(iii) provides, or has provided on the hospital's behalf, the non-federal share of the hospital's payment.

A payment to a hospital under this clause is subject to the availability of non-federal dollars. The payment to each hospital shall not exceed ninety percent (90%) of the hospital's Medicaid shortfall. As used in this clause, Medicaid shortfall is the amount of the hospital's Medicaid costs less the hospital's Medicaid reimbursement and any payments received by the hospital under IC 12-15-15-9 and IC 12-15-15-9.5. For state fiscal years ending before July 1, 2008, the total payments made under this clause may not exceed a total amount of twenty-three million five hundred thousand dollars ($23,500,000). For a state fiscal year ending after June 30, 2008, the total payments made under this clause may not exceed a total amount of twenty-three million five hundred thousand dollars ($23,500,000) plus the annual percentage growth in the state's aggregate Medicaid upper payment limit, as determined by the office.

(D) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) through (C), the remaining amount shall be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for payment under this clause if the hospital provides, or has provided on the hospital's behalf, the non-federal share of the hospital's payment.

(E) As used in clauses (A) through (D), a hospital's Medicaid inpatient days are based on the hospital's Medicaid paid claims and Medicaid managed care days for the current state fiscal year, as determined by the office.".

Page 12, line 24, delete "." and insert "**or subsection (c).**".

Page 12, line 25, after "(b)" insert "**or subsection (c)**".

Page 12, line 28, after "(b)" insert "**or subsection (c)**".

Page 12, between lines 32 and 33, begin a new paragraph and insert:

"SECTION 8. IC 12-15-15-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and:

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, **and before July 1, 2006,** a hospital licensed under IC 16-21-2 that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5 is entitled to a payment under ~~this section.~~ **subsection (c).**

(c) Except as provided in section 9.8 of this chapter and subject to section 9.6 of this chapter, for a state fiscal year, the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP SIX of the following STEPS:

STEP ONE: Identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 during the state fiscal year; and

(B) the county to which each payable claim is attributed.

STEP TWO: For each county identified in STEP ONE, identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 attributed to the county during the state fiscal year; and

(B) the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP THREE: For each county identified in STEP ONE, identify the amount of county funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP FOUR: For each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, calculate the

hospital's percentage share of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b). Each hospital's percentage share is based on the total amount of the hospital's payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year, calculated as a percentage of the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP FIVE: Subject to subsection (j), for each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, multiply the hospital's percentage share calculated under STEP FOUR by the amount of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP SIX: Determine the sum of all amounts calculated under STEP FIVE for each hospital identified in STEP ONE with respect to each county identified in STEP ONE.

(d) For state fiscal years beginning after June 30, 2006, a hospital that received a payment determined under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2006, shall be paid in an amount equal to the amount determined for the hospital under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2006.

~~(d)~~ **(e)** A hospital's payment under subsection (c) **or (d)** is in the form of a Medicaid ~~add-on~~ **supplemental** payment. The amount of a hospital's ~~add-on~~ **Medicaid supplemental** payment is subject to the availability of funding for the non-federal share of the payment under subsection ~~(c).~~ **(f).** The office shall make the payments under ~~subsection~~ **subsections** (c) **and (d)** before December 15 that next succeeds the end of the state fiscal year.

~~(c)~~ **(f)** The non-federal share of a payment to a hospital under subsection (c) **or (d)** is funded from the funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) of each county to which a payable claim under IC 12-16-7.5 submitted to the division during the state fiscal year by the hospital is attributed.

~~(f)~~ **(g)** The amount of a county's transferred funds available to be used to fund the non-federal share of a payment to a hospital under subsection (c) **or (d)** is an amount that bears the same proportion to the total amount of funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) that the total amount of the hospital's payable claims under IC 12-16-7.5 attributed

to the county submitted to the division during the state fiscal year bears to the total amount of all hospital payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year.

~~(g)~~ **(h)** Any county's funds identified in subsection ~~(f)~~ **(g)** that remain after the non-federal share of a hospital's payment has been funded are available to serve as the non-federal share of a payment to a hospital under section 9.5 of this chapter.

~~(h)~~ **(i)** For purposes of this section, "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).

~~(i)~~ **(j)** For purposes of this section:

(1) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(2) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

~~(j)~~ **(k)** The amount calculated under STEP FIVE of subsection (c) for a hospital with respect to a county may not exceed the total amount of the hospital's payable claims attributed to the county during the state fiscal year.".

Page 13, line 6, after "2003," insert "**but before July 1, 2006,**".

Page 13, line 14, strike "this section." and insert "**subsection (c).**".

Page 14, between lines 15 and 16, begin a new paragraph and insert:

"**(d) For state fiscal years beginning after June 30, 2006, a hospital that received a payment determined under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2006, will be paid an amount equal to the amount determined for the hospital under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2006.**".

Page 14, line 16, strike "(d)" and insert "**(e)**".

Page 14, line 16, after "(c)" insert "**or (d)**".

Page 14, line 17, strike "add-on" and insert "**supplemental**".

Page 14, line 19, strike "(e)." and insert "**(f).**".

Page 14, line 20, after "(c)" insert "**or (d)**".

Page 14, line 22, strike "(e)" and insert "**(f)**".

Page 14, line 23, after "(c)" insert "**or (d)**".

Page 14, line 25, strike "To the extent possible,".

Page 14, strike lines 26 through 41.

Page 14, line 42, strike "(f)" and insert "**(g)**".

Page 14, line 42, strike "(g)," and insert "**(h),**".

Page 15, line 3, strike "(g)" and insert "**(h)**".

Page 15, line 12, strike "(h)" and insert "**(i)**".

Page 15, line 15, delete "IC 12-15-20-2(6)(D)." and insert "**IC 12-15-20-2(8).**".

Page 15, line 16, strike "(i)" and insert "**(j)**".

Page 16, line 21, after "under" insert "**IC 12-15-16, IC 12-15-17, or IC 12-15-19 of**".

Page 16, line 31, strike "or".

Page 16, line 33, delete "." and insert "; **or**

(3) other permissible sources of non-federal share dollars.".

Page 16, between lines 40 and 41, begin a new paragraph and insert:

"SECTION 12. IC 12-15-19-2.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2.1. (a) For each state fiscal year ending on or after June 30, 2000, the office shall develop a disproportionate share payment methodology that ensures that each hospital qualifying for disproportionate share payments under IC 12-15-16-1(a) timely receives total disproportionate share payments that do not exceed the hospital's hospital specific limit provided under 42 U.S.C. 1396r-4(g). The payment methodology as developed by the office must:

(1) maximize disproportionate share hospital payments to qualifying hospitals to the extent practicable;

(2) take into account the situation of those qualifying hospitals that have historically qualified for Medicaid disproportionate share payments; and

(3) ensure that payments net of intergovernmental transfers made by or on behalf of qualifying hospitals are equitable.

(b) Total disproportionate share payments to a hospital under this chapter shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year shall be determined by the office taking into account data provided by each hospital that is considered reliable by the office based on a system of periodic audits, the use of trending factors, and an appropriate base year determined by the office. The office may require independent certification of data provided by a hospital to determine the hospital's hospital specific limit.

(c) The office shall include a provision in each amendment to the state plan regarding Medicaid disproportionate share payments that the office submits to the federal Centers for Medicare and Medicaid

Services that, as provided in 42 CFR 447.297(d)(3), allows the state to make additional disproportionate share expenditures after the end of each federal fiscal year that relate back to a prior federal fiscal year. However, the total disproportionate share payments to:

(1) each individual hospital; and

(2) all qualifying hospitals in the aggregate;

may not exceed the limits provided by federal law and regulation.

(d) ~~The office shall, in each state fiscal year, provide sufficient funds for acute care hospitals licensed under IC 16-21 that qualify for disproportionate share payments under IC 12-15-16-1(a). Funds provided under this subsection:~~

~~(1) do not include funds transferred by other governmental units to the Medicaid indigent care trust fund; and~~

~~(2) must be in an amount equal to the amount that results from the following calculation:~~

~~STEP ONE: Multiply twenty-six million dollars ($26,000,000) by the federal medical assistance percentage.~~

~~STEP TWO: Subtract the amount determined under STEP ONE from twenty-six million dollars ($26,000,000).~~

A hospital that receives a payment under clause (B) of STEP FIVE of IC 12-15-15-1.5(c) is not eligible for a disproportionate share payment under this section.

SECTION 13. IC 12-15-19-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 6. (a) The office is not required to make disproportionate share payments under this chapter from the Medicaid indigent care trust fund established by IC 12-15-20-1 until the fund has received sufficient deposits to permit the office to make the state's share of the required disproportionate share payments.

(b) If:

(1) sufficient deposits have not been received; **or**

(2) the statewide Medicaid disproportionate share allocation is not sufficient to provide federal financial participation for the entirety of all eligible disproportionate share hospitals' specific limits;

the office ~~shall~~ **may** reduce disproportionate share payments **under IC 12-15-19-2.1** to ~~all~~ eligible institutions by ~~the same~~ **a** percentage **as long as, for each state fiscal year beginning after June 30, 2006, a hospital established under IC 16-22-8 receives at least sixty percent (60%) of the hospital's remaining hospital specific limit for each state fiscal year.** The percentage reduction shall be sufficient to ensure that payments do not exceed the **statewide Medicaid**

disproportionate share allocation or the amounts that can be financed with the ~~state~~ **non-federal** share that is in the fund, **intergovernmental transfers, certifications of public expenditures, or other permissible sources of non-federal match.**".

Page 17, line 4, delete "," and insert "**and the total amount available for municipal disproportionate share payments in subsection (d),**".

Page 17, line 12, strike "the amount of".

Page 17, strike line 13.

Page 17, line 14, strike "IC 12-15-16-6 or sections 1 or 2.1 of this chapter." and insert "**all Medicaid payments, including Medicaid supplemental payments and other Medicaid disproportionate share payments received by the provider.**".

Page 17, line 22, strike "disproportionate share" and insert "**Medicaid supplemental**".

Page 17, line 23, strike "equals" and insert "**do not exceed**".

Page 18, line 8, delete "is forty million dollars ($40,000,000)." and insert "**may not exceed thirty-five million dollars ($35,000,000).**".

Page 18, between lines 8 and 9, begin a new paragraph and insert:

"SECTION 14. IC 12-15-19-10, AS AMENDED BY P.L.2-2005, SECTION 49, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 10. For state fiscal years beginning after June 30, 2000, **and ending June 30, 2003**, the state shall pay providers as follows:

(1) The state shall make municipal disproportionate share provider payments to providers qualifying under IC 12-15-16-1(b) until the state exceeds the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)).

(2) After the state makes all payments under subdivision (1), if the state fails to exceed the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)), the state shall make disproportionate share provider payments to providers qualifying under IC 12-15-16-1(a).

(3) After the state makes all payments under subdivision (2), if the state fails to exceed the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)), or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)), the state shall make community mental health center disproportionate share provider payments to providers qualifying under IC 12-15-16-1(c).".

Page 18, reset in roman lines 22 and 23.

Page 18, line 24, reset in roman "(7)".

Page 18, line 24, delete "(5)".

Page 18, line 25, after "(D)" insert ",".

Page 18, line 25, strike "and".

Page 18, line 25, delete "." and insert ", **and (8)(G).**".

Page 18, line 26, reset in roman "(8)".

Page 18, line 26, delete "(6)".

Page 19, line 23, after "2003," insert "**but before July 1, 2005,**".

Page 19, line 36, reset in roman "the non-federal share of payments to hospitals under".

Page 19, reset in roman line 37.

Page 19, line 38, reset in roman "under IC 12-15-15-9.5,".

Page 19, reset in roman lines 41 through 42.

Page 20, reset in roman lines 1 through 9.

Page 20, line 10, reset in roman "(F)".

Page 20, line 10, delete "(E)".

Page 20, line 11, delete "2006," and insert "**2005,**".

Page 20, line 29, delete "(F)" and insert "**(G)**".

Page 20, line 29, delete "2006," and insert "**2005,**".

Page 20, line 30, delete "entirety of the" and insert "**total amount of**".

Page 20, line 31, delete "for" and insert "**as follows:**

(1) Thirty million dollars ($30,000,000) shall be transferred to the office for the Medicaid budget.

(2) An amount not to exceed eleven million six hundred fifty thousand dollars ($11,650,000) to fund the non-federal share of payments to hospitals under IC 12-15-15-9 and IC 12-15-15-9.5.

(3) An amount not to exceed eight million nine hundred seventy-five thousand dollars ($8,975,000) to fund the non-federal share of payments to hospitals made under clause (A) of STEP FIVE of IC 12-15-15-1.5(c).

(4) To fund the non-federal share of payments to hospitals made under clause (B) of STEP FIVE of IC 12-15-15-1.5(c).

(5) To fund the non-federal share of payments to hospitals made under clause (C) of STEP FIVE of IC 12-15-15-1.5(c).

(6) To fund the non-federal share of disproportionate share payments to hospitals under IC 12-15-19-2.1.

(7) If additional funds are available after making payments under subdivisions (1) through (6), to fund other Medicaid supplemental payments for hospitals approved by the office and included in the state Medicaid plan.".

Page 20, delete lines 32 through 34.

Page 20, line 36, after "Sec. 2." insert "**(a)**".

Page 20, line 37, delete "year," and insert "year **ending before July 1, 2005,**".

Page 20, reset in roman line 39.

Page 20, line 40, reset in roman "(2) Second,".

Page 20, line 40, delete "(1) First,".

Page 20, line 42, reset in roman "(3) Third,".

Page 20, line 42, delete "(2) Second,".

Page 21, reset in roman line 3.

Page 21, line 4, reset in roman "(5) Fifth,".

Page 21, line 4, delete "(3) Third,".

Page 21, line 6, reset in roman "(6) Sixth,".

Page 21, line 6, delete "(4) Fourth,".

Page 21, reset in roman lines 8 and 9.

Page 21, between lines 9 and 10, begin a new paragraph and insert:

"**(b) For each state fiscal year ending after June 30, 2005, subject to section 3 of this chapter, the office shall make the payments identified in this section in the following order:**

(1) First, the payment under IC 12-15-20-2(8)(G).

(2) Second, payments under IC 12-15-15-1.1 and IC 12-15-15-1.3.

(3) Third, payments under IC 12-15-19-8.

(4) Fourth, payments under IC 12-15-15-9 and IC 12-15-15-9.5.

(5) Fifth, payments under clause (A) of STEP FIVE of IC 12-15-15-1.5(c).

(6) Sixth, payments under clause (B) of STEP FIVE of IC 12-15-15-1.5(c).

(7) Seventh, payments under clause (C) of STEP FIVE of IC 12-15-15-1.5(c).

(8) Eighth, payments under clause (D) of STEP FIVE of IC 12-15-15-1.5(c).

(9) Ninth, payments under IC 12-15-19-2.1 for disproportionate share hospitals.".

Page 21, line 32, after "program." insert "**The department of insurance and the office of the secretary shall provide oversight on the marketing practices of the program.**".

Page 21, between lines 40 and 41, begin a new paragraph and insert:

"**(d) The program must include the following in a manner and to the extent determined by the office:**

(1) Mental health care services.

(2) Inpatient hospital services.

(3) Prescription drug coverage.

(4) Emergency room services.

(5) Physician office services.

(6) Diagnostic services.

(7) Outpatient services, including therapy services.

(8) Disease management.

(9) Home health services.

(10) Urgent care center services.".

Page 24, line 25, after "Sec. 12." insert "**(a)**".

Page 24, between lines 39 and 40, begin a new paragraph and insert:

"**(b) An insurer or a health maintenance organization that has contracted with the office to provide health insurance under the program shall also offer to provide the same health insurance to the following:**

(1) An individual who has an annual household income that is:

(A) not more than two hundred percent (200%) of the federal income poverty level but the individual is not eligible for the program because of the individual's income or because a slot is not available for the individual; or

(B) more than two hundred percent (200%) of the federal income poverty level.

(2) The employees of an employer if:

(A) the employees have an annual household income that is more than two hundred percent (200%) of the federal income poverty level; and

(B) the employer:

(i) has not offered employees health care insurance in the previous twelve (12) months; and

(ii) pays at least fifty percent (50%) of the premium for the employer's employees.

The state does not provide funding for coverage provided under this subsection.".

Page 25, line 19, delete "The" and insert "**Either:**

(A) the individual is no longer eligible for the program because the individual's annual household income exceeds the amounts set forth in section 5(a)(3) of this chapter; or

(B) the".

Page 27, delete lines 10 through 42.

Delete page 28.

Page 29, delete lines 1 through 33.

Page 30, line 21, delete "Except as provided in subsection (c), before" and insert "Before".

Page 31, line 1, reset in roman "IC 12-15-20-2(8)(D)".

Page 31, line 1, delete "IC 12-15-20-2(6)(D)" and insert "**or IC 12-15-20-2(8)(G)**".

Page 31, delete lines 8 through 24.

Page 31, line 25, reset in roman "(c)".

Page 31, line 25, delete "(d)".

Page 31, line 30, strike "(a) For purposes of this section,".

Page 31, strike line 31.

Page 31, line 32, strike "(b)" and insert "**(a)**".

Page 31, line 39, strike "(c)" and insert "**(b)**".

Page 31, line 39, reset in roman "first".

Page 31, line 39, after "payable" delete ",".

Page 31, line 39, reset in roman "in 2004,".

Page 31, line 40, after "2008," insert "**and each year thereafter,**".

Page 31, line 41, strike "product of:" and insert "**hospital care for the indigent program property tax levy for taxes first due and payable in the preceding calendar year multiplied by the statewide average assessed value growth quotient, using all the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for the year in which the tax levy under this subsection will be first due and payable.**".

Page 31, strike line 42.

Page 32, strike lines 1 through 15.

Page 33, between lines 9 and 10, begin a new paragraph and insert:

"SECTION 21. IC 27-8-5-16 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 16. Except as provided in sections 17 and 24 of this chapter, no policy of group accident and sickness insurance may be delivered or issued for delivery to a group that has a legal situs in Indiana unless it conforms to one (1) of the following descriptions:

(1) A policy issued to an employer or to the trustees of a fund established by an employer (which employer or trustees must be deemed the policyholder) to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(A) The employees eligible for insurance under the policy must be all of the employees of the employer, or all of any class or classes of employees. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, members, and partners of one (1) or more affiliated corporations, proprietorships, limited liability

companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" includes elected or appointed officials.

(B) The premium for the policy must be paid either from the employer's funds, from funds contributed by the insured employees, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(2) A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two (2) or more creditors (which creditor, holding company, affiliate, trustee, trustees, or agent must be deemed the policyholder) to insure debtors of the creditor, or creditors, subject to the following requirements:

(A) The debtors eligible for insurance under the policy must be all of the debtors of the creditor or creditors, or all of any class or classes of debtors. The policy may provide that the term "debtors" includes:

(i) borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(ii) the debtors of one (1) or more subsidiary corporations; and

(iii) the debtors of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the policyholder and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control.

(B) The premium for the policy must be paid either from the creditor's funds, from charges collected from the insured debtors, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be

derived from the funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

(C) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

(D) The amount of the insurance payable with respect to any indebtedness may not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments that are delinquent on the date the debtor becomes disabled as defined in the policy.

(E) The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. Each payment under this clause must reduce or extinguish the unpaid indebtedness of the debtor to the extent of the payment, and any excess of the insurance must be payable to the insured or the estate of the insured.

(F) Notwithstanding clauses (A) through (E), insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan, and insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

(3) A policy issued to a labor union or similar employee organization (which must be deemed to be the policyholder) to insure members of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

(A) The members eligible for insurance under the policy must be all of the members of the union or organization, or all of any class or classes of members.

(B) The premium for the policy must be paid either from funds of the union or organization, from funds contributed by the insured members specifically for their insurance, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(4) A policy issued to a trust or to one (1) or more trustees of a

fund established or adopted by two (2) or more employers, or by one (1) or more labor unions or similar employee organizations, or by one (1) or more employers and one (1) or more labor unions or similar employee organizations (which trust or trustees must be deemed the policyholder) to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(A) The persons eligible for insurance must be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes of employees or members. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. The policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with the trusteeship.

(B) The premium for the policy must be paid from funds contributed by the employer or employers of the insured persons, by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and one (1) or more employers, unions, or similar employee organizations. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(5) A policy issued to an association or to a trust or to one (1) or more trustees of a fund established, created, or maintained for the benefit of members of one (1) or more associations. The association or associations must have at the outset a minimum of

one hundred (100) persons, must have been organized and maintained in good faith for purposes other than that of obtaining insurance, must have been in active existence for at least one (1) year, and must have a constitution and bylaws that provide that the association or associations hold regular meetings not less than annually to further purposes of the members, that, except for credit unions, the association or associations collect dues or solicit contributions from members, and that the members have voting privileges and representation on the governing board and committees. The policy must be subject to the following requirements:

(A) The policy may insure members or employees of the association or associations, employees of members, one (1) or more of the preceding, or all of any class or classes of members, employees, or employees of members for the benefit of persons other than the employee's employer.

(B) The premium for the policy must be paid from funds contributed by the association or associations, by employer members, or by both, from funds contributed by the covered persons, or from both the covered persons and the association, associations, or employer members.

(C) Except as provided in clause (D), a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for the insurance must insure all eligible persons, except those who reject such coverage in writing.

(D) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(6) A policy issued to a credit union, or to one (1) or more trustees or an agent designated by two (2) or more credit unions (which credit union, trustee, trustees, or agent must be deemed the policyholder) to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee, trustees, or agent, or any of their officials, subject to the following requirements:

(A) The members eligible for insurance must be all of the members of the credit union or credit unions, or all of any class or classes of members.

(B) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in clause (C), must insure all eligible members.

(C) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

(7) A policy issued to cover persons in a group specifically described by another law of Indiana as a group that may be covered for group life insurance. The provisions of the group life insurance law relating to eligibility and evidence of insurability apply to a group health policy to which this subdivision applies.

(8) A policy issued to a trustee or agent designated by two (2) or more small employers (as defined in IC 27-8-15-14) as determined by the commissioner under rules adopted under IC 4-22-2.

SECTION 22. IC 27-8-5-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 17. (a) A group accident and sickness insurance policy shall not be delivered or issued for delivery in Indiana to a group that is not described in section 16(1)(A), 16(2)(A), 16(3)(A), 16(4)(A), 16(5)(A), 16(6)(A), ~~or~~ 16(7), **or 16(8)** of this chapter unless the commissioner finds that:

(1) the issuance of the policy is not contrary to the best interest of the public;

(2) the issuance of the policy would result in economies of acquisition or administration; and

(3) the benefits of the policy are reasonable in relation to the premiums charged.

(b) Except as otherwise provided in this chapter, an insurer may exclude or limit the coverage under a policy described in subsection (a) on any person as to whom evidence of individual insurability is not satisfactory to the insurer.".

Page 33, delete lines 36 through 39.

Page 35, between lines 28 and 29, begin a new paragraph and insert:

"SECTION 29. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "small employer" means any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.**

(b) The commissioner of the department of insurance and the office of the secretary of family and social services shall, not later

than January 1, 2008, implement a program to allow two (2) or more small employers to join together to purchase health insurance, as described in IC 27-8-5-16(8), as amended by this act.

(c) The commissioner shall adopt rules under IC 4-22-2 necessary to implement this SECTION.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass and be reassigned to the Senate Committee on Appropriations.

(Reference is to SB 503 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 9, Nays 0.

SENATE MOTION

Madam President: I move that Senator Riegsecker be added as coauthor of Senate Bill 503.

MILLER

COMMITTEE REPORT

Madam President: The Senate Committee on Appropriations, to which was referred Senate Bill No. 503, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 9, line 22, strike "subsection" and insert "**section**".

Page 13, line 8, delete "IC 12-15-20-2(7) and insert "**IC 12-15-20-2(8)**".

Page 13, line 13, delete "do" and insert "**does**".

Page 13, line 18, delete "paid claims and Medicaid" and insert "**fee for service and**".

Page 13, line 19, after "care" insert "**paid**".

Page 13, line 29, after "for" insert "**Medicaid**".

Page 13, line 30, delete "under IC 12-15-19-2.1".

Page 13, line 41, delete "extent that" and insert "**availability of**".

Page 13, line 42, delete "are available".

Page 14, line 1, delete "is" and insert "**being**".

Page 14, line 3, delete "limit provided" and insert "**limit, as**

defined".

Page 14, line 4, delete "1396r-4" and insert "**1396r-4,**".

Page 14, line 4, delete "payments are" and insert "**payment is**".

Page 14, line 29, delete "dollars." and insert "**matching funds.**".

Page 14, line 33, delete "reimbursement and" and insert "**reimbursement, including**".

Page 15, line 11, after "hospital's" insert "**in-state**".

Page 15, line 12, delete "paid claims and Medicaid" and insert "**fee for service and**".

Page 15, line 12, after "care" insert "**paid**".

Page 15, line 13, delete "current".

Page 15, line 13, delete "year," and insert "**year referenced in STEP ONE,**".

Page 27, line 11, delete "(before its repeal)".

Page 29, line 31, delete "IC 12-15-20-2(8)(G)." and insert "**IC 12-15-20-2(8)(G)(1).**".

Page 32, between lines 41 and 42, begin a new paragraph and insert:

"**(e) An employer may not contribute more than fifty percent (50%) of the individual's required share to the health care account.**".

Page 35, line 22, after "state" insert "**for deposit in the healthier Indiana insurance fund**".

Page 36, line 4, after "revenues" insert "**and tobacco products tax revenues**".

Page 36, delete lines 10 through 14.

Page 36, line 15, delete "(f)" and insert "**(e)**".

Page 36, line 18, delete "(g)" and insert "**(f)**".

Page 36, line 20, delete "(h)" and insert "**(g)**".

Page 36, delete lines 22 through 30, begin a new paragraph and insert:

"**Sec. 15. (a) The office may not:**

(1) enroll applicants;

(2) approve any contracts with vendors to provide services or administer the program;

(3) incur costs other than those necessary to study and plan for the implementation of the program; or

(4) create financial obligations for the state;

unless both of the conditions of subsection (b) are satisfied.

(b) The office may not take any action described in subsection (a) unless:

(1) there is a specific appropriation from the general assembly to implement the program; and

(2) after review by the budget committee, the budget agency approves an actuarial analysis that demonstrates sufficient funding is reasonably estimated to be available to operate the program for at least the following eight (8) years.

The actuarial analysis under subdivision (2) must clearly indicate the cost and revenue assumptions used in reaching the determination.".

Page 36, line 31, delete "(b)" and insert "**(c)**".

Page 36, line 34, delete "(c)" and insert "**(d)**".

Page 38, line 37, delete "year multiplied by" and insert "**year.**".

Page 38, delete lines 38 through 41.

Page 47, delete lines 2 through 5.

Page 47, line 6, delete "(2)" and insert "**(1)**".

Page 47, line 7, delete "(3)" and insert "**(2)**".

Page 47, line 12, delete "(b)(1), (b)(2), or (b)(3)" and insert "**(b)(1) or (b)(2)**".

and when so amended that said bill do pass.

(Reference is to SB 503 as printed February 9, 2007.)

MEEKS, Chairperson

Committee Vote: Yeas 10, Nays 1.